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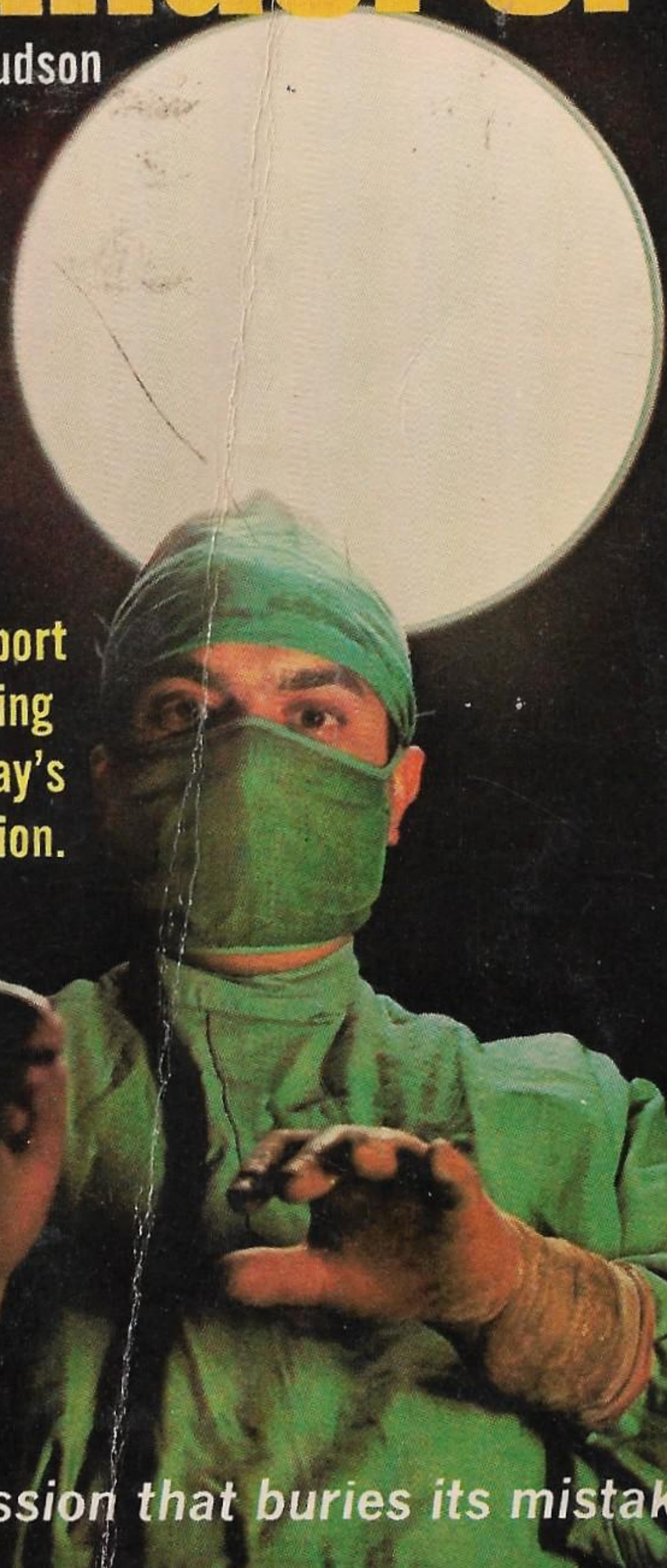
The Blunderers

James A. Hudson



An explosive report on the frightening situation in today's medical profession.

The profession that buries its mistakes

WHO PROTECTS THE PATIENT?

Many patients regard the man with the business-looking stethoscope around his neck as a modern god. But the doctor at times proves to be all too human.

Sometimes he's too ready to prescribe unproven drugs.

Sometimes he's too ready to operate.

Sometimes, when he does operate, he makes a horrible botch of the job. The patient is subjected to needless suffering. Or he dies.

Is it time for a change?

"And when the physician said,
'Sir, you are an old man,'
'That happens,' replied Pausanias,
'because you never were my doctor.'"
—Plutarch (*Laconic Apophthegms of Pausanias*

THE BLUNDERERS

by

JAMES A. HUDSON

A TOWER BOOK

THE BLUNDERERS

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"The remedy is wore than the disease."

—Francis Bacon *(Of Seditions)*

CHAPTER ONE

CONSPIRACY OF SILENCE

Ask almost any American what's the biggest business in the nation. Chances are, he'll be wrong.

Total factory sales of all motor vehicles manufactured in this country—autos, trucks and buses—came to $22,113,700,000 in 1965.* In that same year, the total gross for food products was $3,432,000,000. All private building in that same period totaled $23,580,700,000.

In contrast, the yearly cost for sickness, disability and death in this country is estimated at $74 billion.

Health, then—or lack of the same—is by far America's biggest business.

When we speak of a business of this magnitude, we're conditioned to think in terms of efficiency. Auto-

*The last year for which these statistics are available.

mation has produced miracles on the assembly line. The benefits of modern technology have touched every facet of our lives. So when we read of such medical wonders as heart transplants, kidney donations and the latest in "wonder drugs" perhaps we might be forgiven if we assume that, on all fronts, the art of healing is keeping abreast of our times.

The sad truth is that, while more medical care is available today than ever before, so is there a prevalence of dangerous—sometimes fatal—malpractice.

Just as more people than ever before receive the benefit of medical science, so, too, do innocents fall victim to quacks and charlatans.

Just as the medical profession numbers among its ranks more dedicated and trained specialists with greater scientific knowledge than ever before, so, too, has it been invaded by well-meaning incompetents, dishonest frauds and megalomaniacal butchers.

A current medical scandal which only recently came to light involves the illegal use of silicone injections. These injections are undergone by women to increase their bust measurements. An inquiry disclosed that thousands of women in California and Nevada had received these injections by dozens of unethical doctors. The results have sometimes been heart attacks and blindness. One Los Angeles woman is known to have died after silicone injections caused breast cancer.

The doctors involved continued use of silicone despite the fact that the Food and Drug Administration warned against its use and tried to shut off supplies. Instead of heeding the warning, these get-rich-quick doctors—who receive as much as $50 for a single injection—began using silicone imported from Japan or, even worse, industrial-grade silicone.

Silicone is an oily compound used for such purposes as the lubrication of electrical devices. It will not dissolve in nor be absorbed by the human body. When the injections are successful, the substance remains between the fatty tissues of the female breast. If enough injections are made, it can enlarge the bustline by as much as ten inches.

But many times all does not go well with the injections. The silicone, instead of remaining in place, moves around in the body. One Las Vegas show girl found her injections had become a deposit on her back. In another girl, it drained to the groin and had to be removed by surgery.

A 29-year-old Las Vegas cocktail waitress received eight $50 injections from a doctor in 1964. The silicone entered her bloodstream and was carried to her heart, eyes and lungs. She lapsed into unconsciousness, remained in a coma for four days, for a year had to be led around and still cannot see well.

"It's like I had blind spots," she said. "I look at people and they look like they have no heads."

Though most women who seek the injections are entertainers, many others are nonprofessionals. Whoever they are, they've had little trouble receiving the illegal and dangerous injections. An official source provided a list of 37 doctors who are known to have given the injections. One Las Vegas doctor has four legal suits pending against him, ranging up to $250,000.

But the majority of these doctors continue to flout the law—and to endanger patients' lives. Enforcement officers are handicapped by the fact that women who

receive the silicone injections are reluctant to talk about them—unless the injections go badly.

In such cases, a doctor's office can serve as a dispensary of injury or death. Yet the time when many patients are put into the most extreme jeopardy is when they enter a hospital.

A seven-year study just completed by two Yale University professors pictures the modern hospital as a jungle which the patient enters at great risk. Their findings are shocking by any aspect—not the least being that the hospital they studied was a *first-rate* one.

Dr. Raymond S. Duff, a pediatrician who teaches at Yale University School of Medicine, and Professor August B. Hollingshead, a noted sociologist, reached the conclusion that hospitals are run to suit doctors, nurses, students, teachers, researchers, bureaucrats—everyone except the patients.

Dr. Duff said that in some cases a patient would be safer if he remained at home rather than enter the hospital.

"If a man has what seems to be acute appendicitis, is not too handicapped by family and personal problems, and finds a good surgeon who's not too eager to operate, then the modern hospital is ideally equipped to handle his case," Dr. Duff concluded.

"It also helps if he praises his doctor and nurses and is glad to pay for their services. Then everybody is pleased.

"But if a person comes in with a lot of confusion about his symptoms—for example, chest pains—and a lot of family turmoil that contributes to them, then he is usually in danger of being misdiagnosed and mismanaged. He may be much worse off after the hospital encounter."

Dr. Duff added that even those who survive their hospital experience are often made miserable by the encounter. The disease itself might be cured. But the patient is discharged in a disgusted and confused state of mind. He may even still *feel* sick. This is because no one has paid attention to his fears or bothered to answer his anxious questions.

Duff and Hollingshead have just published their findings in an explosive book.* They made one of the most exhaustive studies ever made of what it means to be in a hospital. They followed 161 patients from the time they entered the hospital until they were discharged—or died.

They concluded that even in this grade-A hospital, the patient was lost in the shuffle. "The patient has an illness; the physician has a career." They found that careers and other economic considerations often left little room for a humane attitude on the part of doctors or attendants. They quoted one medical student as summing up this situation:

"I'm in the hospital to learn, although sometimes the patients don't benefit from this. Sometimes a man suffering with a terminal illness will be kept alive for months on various procedures, which completely deplete the family fortune. All of us learn something from this . . .

"In keeping some patients alive only to suffer and die in pain, we learn something more about keeping patients alive to live."

Later, we'll take a closer look at hospitals which sometimes do a patient more harm than good.

If a hospital patient undergoes surgery, his chances for encountering malpractice increase substantially.

**Sickness and Society*, Harper & Row, New York City.

Cases are on record in which surgeons have performed the wrong operations on patients. Others have removed perfectly healthy organs, just to stop the patients' complaints—and to collect high fees.

Melvin Belli, a noted San Francisco lawyer, has built a thriving business on malpractice cases. He recently appeared on a television program and showed an X-ray of a surgeon's handiwork. The X-ray revealed that a large pair of surgical scissors had been sewn up in the patient's abdomen!

Physicians, when one of their colleagues is accused of malpractice, too often rally around their fallen "fraternity brother" and protect him from the "outside world"—if only by a conspiracy of silence. We shall, as far as possible in this book, penetrate that conspiratorial curtain.

We shall see that, far from being the wise servants of mankind as pictured in such popular fare as the Dr. Kildare series, many doctors are ignorant, careless and indifferent. Many cases are on record in which doctors have prescribed the wrong drug or treatment. Many times the drug is right but the dosage is wrong. The results can be the same: Needless suffering and, sometimes, death.

We shall examine cases in which patients have been sent into sometimes fatal shock by the administering of a drug to which they were allergic. In few if any of these examples was a simple test conducted to see whether the drug, instead of having a healing effect, might act as a deadly poison.

Doctors have always enjoyed a particular kind of trust. More than anyone outside the immediate family, with the possible exception of the clergy, they are given

our confidence, made privy to our hopes and despairs —and many times are entrusted with our very lives.

The great majority of doctors keep faith with the oath of Hippocrates. In this oath they swear "the regime I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong."

A lesser number, however, have been proven to be out for what they can get—regardless of injury to the patient. A similar number have been proved guilty of a criminal lack of knowledge and technique, though their intentions have been honorable.

Perhaps even larger than either of these groups is the number of doctors who are guilty of these attitudes or lacks—though clear legal proof such as Belli demonstrated still is lacking.

These doctors treat thousands of patients every day. If you don't exercise reasonable care in your choice of a doctor, one of these physicians may be treating you.

The object of this book is not to frighten anyone. One of its aims, however, is to make the reader aware of an alarming situation which daily grows more acute. Americans must realize that doctors are, after all, human—sometimes appallingly so in their capacity to err if not practice downright fraud.

Though the medical situation in this country does have its frightening aspects, all is not hopeless. Armed with proper knowedge of that situation, Americans can demand—and eventually will receive—better and more responsible medical care.

This book, hopefully, will help point the way toward that goal.

"Avoid, as you would the plague, a physician who is also a man of business."

—Voltaire (*Essays*)

CHAPTER TWO

A DOCTOR'S OLD FRIEND: THE INVISIBLE KILLER

A visit to the dentist's office is seldom a pleasant experience. Most patients dread drilling, and extractions even more. Yet few are aware that the visit to the dentist can be dangerous. It can, in fact, endanger their lives.

The most dangerous tool used in many dentists' offices is not the drill nor extracting forceps. It's X-rays.

Many dentists make a practice of X-raying their patients' teeth routinely during each visit. This has become such a standard procedure that the *Journal of the American Dental Association* recently felt compelled to remind its readers:

"Radiographic examinations should not be made periodically or be a standard part of every dental

examination, and should only be used if the information to be obtained will contribute to proper diagnosis and prevention of disease."

The A.D.A. voiced concern because it was aware that X-rays frequently can be a silent, invisible health hazard. Improperly used, they can cause fatal disease among members of the present generation and threaten the health of children yet unborn.

While penetrating a patient's body, seeking its secrets, X-ray radiation can also do it irreparable harm. Depending on how much radiation is absorbed by the body, it can cause a shorter life span, trigger leukemia and other forms of cancer, bring on eye cataracts and cause genetic damage. The latter can affect future generations by making children mentally retarded, physically deformed or otherwise disabled.

Despite these dangers, comparatively few dentists' offices are equipped with lead aprons or other shields to be placed over the patient to protect that part of his body not being X-rayed. Only two states, California and Wisconsin, have laws requiring lead aprons to be furnished dental patients. In other states, it's up to the dentist to decide whether to offer his patients protection. As we've noted, most of them don't.

These protective devices should be mandatory to insure a patient's health because of a tendency of radiation to "scatter."

We've singled out the dentist office because it's here that most people come in frequent contact wih X-rays. But X-ray danger is by no means confined to the dentist's chair. Safety expert Ralph Nader, in a recent article appearing in *Ladies' Home Journal,* wrote:

"X-ray horror stories are not hard to find. In Washington, D.C., a young mother went to an obstetrician

complaining of a dislodged inter-uterine birth-control device. He X-rayed her without finding out if she was pregnant. A few days later this housewife discovered that she was going to have a child and had, indeed, been pregnant when the X-rays were taken.

"Shortly afterward, she lost the baby. There could never be positive proof that the X-ray caused the tragedy; the nature of X-radiation, silent and invisible, building up slowly and cumulatively, makes it difficult to link cause with effect. But there certainly was a potential risk, as there is with all women of child-bearing age, and it should have invited greater care on the part of the obstetrician.

"This was no isolated case. The records show one male patient who underwent 200 X-rays on his right knee in a matter of weeks; when he protested that he'd had hundreds of X-rays, his doctor replied, "Then a few more won't hurt."

"An airline pilot who was subjected to a fluoroscopic examination—much more powerful than X-rays—every six months . . .

"A pregnant woman who was X-rayed repeatedly at a big naval hospital—more, she felt, for the training of Navy Corpsmen than for any valid diagnostic reason. Her baby later died of apparent radiation symptoms . . .

"The list is long and tragic."

Dr. Karl Z. Morgan, director of the health physics division of Oak Ridge National Laboratory, is a pioneer in radiation safety. He says:

"No matter how great the medical benefits derived from X-rays, there is no justification for the fact that because of the use of poor techniques with obsolete and improperly operated equipment many X-ray expo-

sures are ten or more times that needed for the best diagnostic results."

Dr. Morgan isn't suggesting that patients should refuse to allow their doctors or dentists to X-ray them. The X-ray is often a valuable diagnostic tool, and its use can be vital. But patients should be aware of the fact that it can sometimes be deadly, too.

It may shock most laymen to realize that even many medical men remain ignorant of the potential dangers of X-rays.

It may amaze them that so few laws protect the patient from this health hazard.

But deplorable conditions do exist. Compounding the danger of a shortage of medical personnel adequately trained in X-ray technique, the use of inexcusably hazardous X-ray machines is widespread. These machines are hopelessly antiquated, improperly maintained or faultily deisgned. They subject patients to far more X-rays than are technically necessary.

In his article, Nader reported:

"Regularly inspected older machines, equipped with the latest safety devices, can be as safe as new machines. But too few meet these standards of renovation. Studies comparing those machines that are in excellent condition with the other kind show that chest X-ray exposures may range from 10 to 1,000 milliroentgens to the skin surface (the roentgen is the internationally accepted unit of radiation measurement) for the same medical X-rays; dental X-rays may range from 3,000 to 350,000 milliroentgens to the skin surface for the same dental X-ray series.

"In surveys conducted in various states, X-ray machines were also found to be equipped with improper cones or no cones at all. (The cone is the part of the

machine that aims the X-rays onto the film and limits the exposed area of the patient's body. A plastic-covered, closed-in cone four to six inches long is the least desirable kind, according to radiologists; the recommended dental cone is open-ended and at least 12 inches long.) Few of the older cones are lined with protective material, and in many cases the filters have been removed.

"Many doctors and dentists, moreover, use old or stripped-down equipment that lets dangerous quantities of radiation leak from the X-ray tube housing. Many are using still insensitive film—film that is outdated or improperly stored and, most important, slow-speed film. For example, some slow-speed film requires a normal exposure of as much as four seconds, whereas some of the newer fast film requires an exposure of only one-fourth of a second or less. But to use fast film a doctor must buy an electronic timer costing roughly $40."

Despite the potential dangers of X-ray machines, most of them are seldom inspected, remain in poor working condition and are operated by those who may not know what they are doing.

Professor Handon Blatz, director of New York City's Office of Radiation Control, says that 85 per cent of the medical X-ray equipment in that city is owned by physicians who have never taken a single formal course in radiology training. He reports:

"Most physicians who purchase and use X-ray equipment have not had any formal training in the proper operation of such equipment. It would seem that a physician should be required to give some evidence of training and experience before being permitted to purchase and use X-ray equipment."

Nader points out that American medical schools, unlike their European counterparts, offer little or no training in radiation protection and radiation physics. Yale Medical School, for example, gives its students one short course in radiology. And this one deals only with the reading of X-rays.

He quoted Dr. Arthur Wuehrmann, professor of dentistry at the University of Alabama, as saying that the same shortcomings are found at most dental schools.

The sorry mechanical state of X-ray machines currently being used is indicated by Public Health Service statistics. The PHS reported that in 1966, the last year for which such figures are available, 29,518 X-ray units were inspected. Of these, a total of 12,454 were declared defective. But only 9,648 corrections were made.

Expert radiologists might view the situation with more alarm than even these figures indicate. Many machines that pass the lax standards of some states would fail to meet their critical approval. Studies conducted between 1960 and 1964 showed that 57 per cent of the X-ray machines inspected in Polk County, Florida, failed to focus the dangerous X-ray beam properly. Also defective were 66 per cent of the machines in New York City, 58 per cent of those in Baltimore and 41 per cent in Los Angeles.

With the number of X-ray machines growing daily, the ranks of the full-time X-ray inspector remain woefully sparse. Nearly half of this number is accounted for by only three states—New York, Pennsylvania and Illinois.

The PHS reports that Connecticut has two inspectors. One year, in 1965, they reported that 219 of the

2161 X-ray machines they inspected were defective. Total number of corrections made: Two.

Despite the danger involved, indications are that Americans have gone X-ray happy. More X-rays per capita are taken in this country than any other in the world. The PHS says that for every 100 Americans, 62 X-rays are taken each year.

One frightening result of this is a higher gonad dose for Americans. This is the exposure of the reproductive organs to X-rays. Americans are exposed to X-rays in this manner far more than Western Europeans, a people who, in general, enjoy high medical standards. The average American receives 10 times more X-ray exposure to his reproductive organs than citizens of Great Britain and 15 times more than Norwegians.

What effect might all this have on tomorrow's children? No one is in a position to say precisely—including the doctors and dentists who make such liberal use of X-rays, many times under minimal safety conditions or worse.

An even greater potential hazard is the fluoroscopic examination. This process enables the diagnostician to watch X-ray "movies" of the human body. One expert —Dr. William B. Seaman, a radiologist at the Presbyterian Medical Center in New York City—believes that fluoroscopic examination produces 100 times the exposure that X-ray pictures do. But at least one other authority, Professor Hanson Blatz, believes such an examination may produce 200 to 300 times more radiation exposure than X-rays.

The Federal government, which has shown negligence in this field of public safety, at last shows signs that it might do something about it. The U.S. Senate Commerce Committee is currently investigating the

ever-growing X-ray menace. But it may take years before adequate legislation is passed and even longer before efficient enforcement procedures are put into effect.

Meanwhile, patients should be on guard against possible overexposure to X-rays. It's one health hazard to which many doctors and dentists don't pay sufficient regard.

CHAPTER THREE

Rx FROM "FAT DOCTORS": DEADLY REDUCING PILLS

Americans sometimes pay a tragic price for being the richest people in the world. Not only are we the best housed, the best clothed and the best fed. Many of us are the most overweight.

An uncounted number among us seek methods of reducing weight.

Many weight-watchers are aware of the dangers of drastic dieting. They wouldn't dare undertake a severe regimen without placing themselves under medical supervision. Herein lies the rub.

The obesity business has become a multi-million-dollar enterprise among "fat doctors" specializing in weight problems. Some of these do not prescribe an excessive number of pills and do not take any medical steps without first carefully examining the patient. But

many do. And there is reason to believe that some patients have died of pills prescribed by these specialists.

The Food and Drug Administration estimates there are 5,000 to 7,000 "fat doctors" in the United States. About 1,000 of these treat "fatties" exclusively. Among these specialists, osteopaths outnumber M.D.'s by three to one.

"Fat doctors" are visited by five to ten million patients a year. They sell more than two billion diet pills and gross between a quarter and a half billion dollars annually.

The drugs they dispense are not deadly in themselves. When used properly, they can even be helpful. But given in excessive dosages or taken in certain combinations, they can be poisonous, even fatal.

Especially tragic was the case of an attractive 19-year-old college coed who weighed 160 pounds and worried about her weight. She finally went to a "fat doctor."

He prescribed a whole rainbow of brightly colored pills. She became thinner. Her weight dropped to 120 pounds. A year later, she was studying in her dormitory at Oregon State University. With little warning, she died.

Dr. Russell Henry, the Oregon State Medical Investigator, conducted painstaking tests and announced his findings: Cheryl's death had "probably" been caused by the pills. He added that he knew of five and possibly seven other Oregon women who had died in the same manner.

Other suspicious cases have turned up in the United States. Among these:

—Mrs. Norma Jo Jill, of New Braunfels, Texas. She

died in 1965 of "toxic myocarditis." She was 38, had been a weight-control patient. Her husband is suing a doctor for $342,000, alleging that the dead woman was given a variety of drugs without adequate examination or proper supervision. The doctor denied the charges.

—Rose Napoliello, of Sayreville, New Jersey. Her husband, John, received an out-of-court settlement from three obesity-control doctors in Newark. John Napoliello claimed that his wife went to the doctors for treatment of obesity and that, despite her long history of a rheumatic heart disease, they prescribed a number of diet drugs. She later developed embolisms which led to heart and brain damage, amputation of both legs and incapacitation for three years. She then died at the age of 50.

—Mrs. Frances Eleanor Espenschied, of Springfield, Illinois. She was 5 feet-5 inches, weighed 233 pounds and took a large number of diet pills for a year. She died in 1966, aged 51. She had a history of heart trouble, and an autopsy showed digitalis in her system. A toxicological study indicated that no one drug was present in a quantity sufficient to be fatal. But the report raised the question: "Could the combination of drugs have been the wrong one?"

—Mrs. Helen Bailey, of Effingham County, Illinois. She had been on diet pills when she died in 1966 at the age of 43. County Coroner Darrell Holland cited digitalis intoxication as the cause of death.

—Roger E. Schaefer, an Elmhurst, Illinois, policeman. He had been taking diet pills before he died in 1964 at the age of 28. DuPage County Coroner Dr. Samuel K. Lewis listed two possible causes of death: auricular fibrillation (heart spasms) and "allergic reaction to medication."

Dr. Lewis said that positive proof was difficult but added, "I see about one case every six weeks in which I suspect that death was due to diet pills."

Drugs commonly prescribed for obesity are amphetamines, which suppress appetite; barbiturates, which calm whatever nervousness the amphetamines may cause; diuretics, which rid the body of water; thyroid, which steps up the rate at which the body burns food, and digitalis, a heart drug which some experts say has no real place in weight control.

Either thyroid or amphetamines alone can strain the heart.

Certain diuretics—known as thiazides—sometimes cause the body to lose much of its potassium. This, in turn, can make the heart extremely sensitive to digitalis. In such a supersensitive heart, even a small dose of digitalis can trigger violent spasms—and death.

Despite the sometimes tricky nature of diet pills, many "fat doctors" prescribe them as a matter of routine. As a recent article in *Life* magazine put it:

These doctors "run filling-station, cash-and-carry operations, see 100 or so patients a day, give only cursory physical exams or none at all, and carelessly send off their 'customers' with sacks of potent—and possibly deadly—pills."

A girl reporter for *Life*, Susanna McBee, visited ten doctors who treat weight problems. The shapely Miss McBee is 5 feet 5, weighs between 123 and 125 and is a perfect size 10. To carry out her assignment of investigating "fat doctors" she went on a high-calorie diet. She was able to gain only five or six pounds. Still quite trim, she expected to be bounced from the doctors' offices.

"They (the doctors) welcomed me," she reported.

"Although three of them said I had no weight problem and another even congratulated me for catching the problem early (that is, before it developed) they all, every last one of them, gave me diet pills. My 'haul' was 1,479 pills."

The reporter later had a chemist analyze the pills. They included amphetamines, barbiturates, sex hormones, diuretics, thyroid and digitalis.

The first doctor Miss McBee visited was an osteopath, Dr. Edward A. Devins, who less than a month earlier had been raided by agents of the Food and Drug Administration's Bureau of Drug Abuse Control and by a deputy U.S. marshal. The offense Dr. Devins was charged with was failing to keep accurate records of the pills he received and dispensed. The pills the agents seized were mainly amphetamines and barbiturates.

At Dr. Devins' office, as at the others she visited, the *Life* reporter gave her correct name and added a local address and occupation. In each case she told the doctor only that she wanted to lose weight, never asking for pills. At Dr. Devins' Kansas City office, she was handed a form containing 195 questions covering ordinary medical historical facts and going on to probe the patient's mental condition.

Miss McBee reports, "my mental condition was hardly improved by the queries: 'Do you feel alone and sad at a party?' 'Do you often cry?' 'Does life look entirely hopeless?' 'Do you often wish you were dead and away from it all?' "

Miss McBee gave her completed questionnaire to the doctor's assistant who asked her if she were nervous and if she were allergic to medicine. She then weighed Miss McBee, and finding her at her top weight of 130½ pounds, promised to help her get down to 120.

When the doctor himself finally entered the room he was carrying a box of pills. He did not examine Miss McBee. Instead, he advised her against going on a diet and read her the instruction on the box of 140 tablets. Dr. Devins told the reporter to return in a month and directed her to a receptionist who collected a ten dollar fee and sent her off.

From Kansas City, Miss McBee traveled to Decatur, Illinois, Gardena, California, and Los Angeles. In every office she was provided with pills for weight loss.

"Among the 'fat doctors' I visited," Miss McBee wrote, "there was no consensus on diet. . . . Their physical examinations ranged from several tests to merely a weight and measurement check. There was consensus, though, on one point: pills, pills."

And the effects of those pills are not always as innocuous as the "fat doctors'" best bedside manner. In some cases they could even kill the patient.

Of course, this would be something like killing the goose that lays the golden egg. But the "fat doctors" have plenty of such geese.

CHAPTER FOUR

BUT WHO PROTECTS THE PATIENT?

The American Medical Association has been described as one of the most militant labor "unions" in the world. Dentists and psychiatrists, too, have their professional associations. All these organizations act in concert to deal with real or imagined threats to their members' livelihood or welfare. Sometimes this is done at the expense of the health of individual Americans.

The most outstanding example of this is the 20-year battle waged against federal health-assistance by such groups as the AMA. Most doctors threw up their hands at the very idea of government subsidy of medical costs. Their ultimate fear was a diminishing of their fat fees. But their chief weapon was to raise before the public the specter of "socialized medicine."

Congress ended this prolonged debate in 1965, when

it passed the Medicare bill. But in medical care, Americans are still being shortchanged.

One reason for this is that patients, like most other consumer groups, have relatively little organized support. When a patient is caught in an economic squeeze or is otherwise abused by health merchants, he stands —or, more likely, lies—alone.

True, governmental agencies, now grouped around the Department of Health, Education and Welfare, do safeguard public health to some extent. But their exact responsibilities often have been vague, their enforcement powers limited.

This sometimes has resulted in mistakes or short cuts which have posed hazards to the public welfare. A recent example is the thalidomide scandal. Despite governmental safeguards, this incompletely tested drug found its way into this country and was tested on a number of unsuspecting patients. It may be safe to assume that, except for a fluke of fate which we'll discuss in the next chapter, its use might have become much more widespread in this country. Throughout the rest of the world, this drug's victims are still paying in grief as well as money for official ineptitude or lack of stringent laws covering such drugs—laws which this country also lacked.

Thalidomide, sold as a sleep-inducing drug, was advertised as safe even for pregnant women. Before it was withdrawn from the market, it caused the birth of 7,000 monster infants throughout the world.

Some of these babies had mere stumps for arms. These stumps sometimes ended with only two to four fingers, sometimes with none at all. These malformations in some cases were accompanied by other serious defects. Some babies were minus an outer ear. In

some, the auditory passages were closed. In others, it was the esophagus. A number had heart trouble.

In each case, the mother had taken the drug during pregnancy. While perhaps safe for some users, the drug had a devastating effect upon the fetus when taken by expectant mothers.

Those whose lives are marred by such a drug do, of course, have legal recourse. A trial, expected to be extremely lengthy, is now underway in Aachen, Germany, in which parents of thalidomide-damaged children seek damages against the drug's manufacturers, the Chemie Grunenthal, of Stolberg, Germany.

But for most of these parents, whatever action is taken by the court, it will be too little and too late. Some of the babies thus affected died, some were killed. Most of the living will have to go through a lifetime of being maimed.

One of the most significant aspects of this trial is its underscoring of the comparative ease with which a dangerous drugs raises the question: Who protects the German manufacturers sold thalidomide to licensees in many countries with assurances that it was completely safe, apparently when there was no basis for such certainty. One of the licensees was the National Drug Company in the United States, a division of Richardson-Merrell, Inc.

Too late for many victims, the free commerce of dangerous drugs raises the question: Who protects the patient in such cases?

The federal government sets up safety standards for other imports—including smog-suppressant devices on foreign autos.

Shouldn't it be at least as concerned with the safety of imported drugs?

The government spends millions of dollars annually apprehending and prosecuting those who illegally peddle drugs known to be dangerous. The penalties are servere. Even to transport marijuana for one's personal use is a serious crime—despite the fact that the authorities don't agree on its degree of danger to the user, if any.

Without engaging in this debate, might we not question whether the government shouldn't be more concerned in supervising the testing of drugs with an unknown potential for destruction?

Improperly tested drugs, about which we'll have more to say later, is only one area in whch the medical consumer lacks full protection. In some areas he seems to have little protection at all. This is particularly true if he happens to be poor.

Despite the recently inaugurated Medicare program, statistics are damning in their indictment of total health care in the United States. For while Americans pay a bigger medical bill than any other nationals—some $74 billion a year—our nation's health ranks far behind that of less affluent countries.

For example, in the prevention of infant mortality, the U.S. stands only tenth among countries of the world.

In prolonging life, the U.S. is in a shameful eighth place.

Each day, fantastic treatments are made and operations performed in America's medical centers. So advanced is our medical technology on one hand that many of these treatments and surgical feats would have been considered just a science-fiction writer's dream only a decade ago.

On the other hand, those who haven't been able to

afford the high price of such advanced treatment seldom have received it. In fact, they've been lucky to receive any treatment at all.

Until now, when it comes to medical treatment, ours has been a schizophrenic society. While the citizen of means has purchased fantastic medical treatment, the medically indigent has continued to suffer and die from diseases which, at least in theory, were "outlawed" decades ago.

This disparity in medical treatment has allowed the national average to become a disgrace. As Dr. H. Jack Geiger, professor at Tufts University School of Medicine, in Boston, puts it:

"The health of the poor is an ongoing, national disaster. The poor are likelier to be sick; the sick, likelier to be poor."

A comparison of infant mortality rates in this country is enough in itself to convince more observers that, medically speaking, the poor are second-class citizens.

In Chicago, babies born to high-income families die at the rate of 15 for every 1,000 births. Among the poor in that city, the rate is 33.

In Mississippi, the death rate for white infants is 23. For Negroes, it's 53.2.

In Michigan, the death rate for white infants is 21. For nonwhites it's 39.1.

The terms "low-income," "nonwhite" and "Negro" do not, of course, have precisely the same meaning. But it should be pointed out that Negroes comprise 95 per cent of the nonwhites in this country, and most of them do fall into the low-income bracket. The statistics cited obviously mean, then, that in some states—North as well as South—babies born to most Negro families

are about twice as likely to die as white babies. In fact, this holds true in all but three of the 50 states.

Infant care isn't the only medical area in which the U.S. has failed its citizens. Dr. Carruth J. Wagner, director of the U.S. Bureau of Health Services, says this country "leads many other countries in the incidence of disease, premature death, delinquency, alcoholism and social problems, while spending more per capita on health than do these countries."

Though a number of the medically indigent can now be expected to benefit from Medicare, there are other outstanding medical-attention gaps which still cause suffering and death among rich and poor alike. This, too, can be traced to the fact that the medical consumer—who at any given moment can be any of us—has little protection regardless of his financial state.

What happens, for example, if you're struck by an automobile? In many cases, the answer is simple: You'll lie there and die.

Dr. Robert H. Kennedy maintains that at least 20,000 more persons would be alive today if they had received prompt emergency ambulance care.

In addition, he says, another 25,000 victims would have been spared permanent injury and disability.

Dr. Kennedy was a New York surgeon for 45 years before retiring in September, 1960. He immediately began another job—that of looking into the reasons why emergency care of the injured is wholly inadequate.

He was named field director of a committee set up by the American College of Surgeons and the John A. Hartford Foundation. He began his task by visiting some 200 cities and towns and inspecting some 400 ambulance services. "The early discoveries shook me

up quite a bit," the doctor admits. Among his discoveries:

—None of the 50 states could tell him how many ambulances they had. Nor did they know how many people manned them.

—Many ambulances were manned only by the driver. The patient, no matter how seriously injured, rode in the back alone.

—Many ambulances were not equipped to give emergency care.

—All a driver needed in some states to become a private ambulance "service" was a stretcher and a station wagon.

"Until last year," Dr. Kennedy says, "New York was one of those states. Then the legislature passed a bill with standards for ambulances, equipment and services. The state medical society didn't know about it until the governor signed it."

Dr. Kennedy points out that emergency service in even such a comparatively sophisticated city as New York is a jungle of confusion. Emergency service there is furnished by 15 municipal and 27 voluntary hospitals, 30 private operators and 20 volunteer rescue squads in outlying areas.

On a nationawide basis, half the emergency service is supplied by hospitals, police and fire departments, by private operators and rescue squads. Where does the other half come from? Funeral directors.

The latter often race one another to accident scenes —sometimes not to aid the injured but to retrieve the dead. The injured, meanwhile, are left lying there.

Burying the dead, after all, is usually a source of far greater profits than giving quick attention to the injured.

"I hear that only two states have laws requiring an ambulance to take the living before the dead," said Dr. Kennedy. "One policeman told me that after a bad accident he had to draw his gun to get a funeral director with an ambulance to take the living to the hospital before he took the dead."

That was one isolated case in which the patient was lucky enough to have someone at hand to protect him.

But in many cases—whether they're accident victims, innocents taking prescriptions for untested drugs, or poor persons who can't afford the latest in medical care—the medical consumer has little or no protection.

Unlike the doctors who attend them, patients have no "union."

CHAPTER FIVE

UNTESTED DRUGS: CURES OR KILLERS?

For the fact that the United States does not have thousands of thalidomide-crippled children, its citizens can thank a modest but persistent woman doctor. Her name is Dr. Frances Oldham Kelsey. Virtually single-handedly, she faced down all attempts to have the drug placed on the shelves of U. S. drugstores.

The study of Dr. Kelsey's successful fight against this drug is a revealing one. It shows how our health and sometimes our lives can hang by the most fragile thread. In fact, as we'll see, if it hadn't been for Dr. Kelsey's browsing through a foreign medical journal during an idle moment, this crippling drug might have been distributed even more widely in this country.

This episode is worth examining for other reasons. We've mentioned the apparent ease with which un-

tested drugs have crossed international borders. But Dr. Kelsey's story also raised serious questions about the testing standards which drug manufacturers in this country had been forced to meet. It raised another, perhaps equally important question: And that is, to what lengths should pharmaceutical firms be permitted to try to influence a government doctor charged with the weighty responsibility of declaring a drug safe or unsafe for human consumption?

Dr. Kelsey looks like none of the common stereotypes of a hero. She isn't particularly athletic-looking. She isn't particularly tall. Chances are, in a crowd you wouldn't pick her out as being exceptional in any regard. She was 48 at the time she became a hero. She habitually wore conservative clothes, flat heels, and no makeup at all.

Her distaste for makeup probably has little to do with her feminine ideals of natural beauty. It probably stems from the fact that she's too familiar with the stuff of which most makeup is made.

Dr. Kelsey is a medical officer in the Federal Drug Administration. In 1960, she was given a routine assignment. Working in a drab office of the FDA, she was to study an American manufacturer's application to concoct and sell thalidomide in the U.S. market.

A less conscientious doctor than Frances Kelsey might well have considered the application even less than routine. Thalidomide had been manufactured and sold in Germany for quite some time, apparently to everyone's satisfaction that it was an excellent sleep-inducing drug. And we all know how methodical and critical the Germans are.

Dr. Kelsey had been working for the government less than a month. She was the careful type. She wasn't

going to rubber-stamp the application, no matter how routine the matter seemed.

In time, she withheld her approval of the drug because in laboratory tests it "behaved differently" from other drugs to which it was chemically akin.

Probably some workers in the FDA, hearing of her action, thought that Dr. Kelsey was being a show-off. That new worker, wasn't she? Probably trying to butter up the boss.

Actions such as hers don't win a government medical officer many friends. As months passed, the pressure was applied to Dr. Kelsey.

She was given the drug application in September, 1960. In February, 1961, she happened to be browsing through the British Medical Journal and read a letter which stirred her interest. It was from a British doctor. He suggested that the drug Dr. Kelsey was studying might be causing some patients to suffer peripheral neuritis, a tingling sensation in the arms and legs.

Dr. Kelsey promptly notified the American manufacturers, the Merrell Co., of what she had read.

Notice how slowly events can move when the safety of a drug is being questioned. Remember, too, that despite the laws governing the manufacture, testing and sale of drugs in this country, thalidomide had been offered to some American doctors so they could test the drug on their own patients. All this was perfectly legal!

About March of 1961, after receiving Dr. Kelsey's letter, the Merrell Co. sent one of its investigators to London. He learned that there was evidence, indeed, that a relationship might exist between thalidomide and peripheral neuritis. The company then notified the

American doctors testing the drug to be on the alert for such side effects.

Dr. Kelsey still wasn't satisfied with her investigation of the drug. She wasn't sure that a slight tingling in the arms and legs was all the damage thalidomide could cause in some patients. After more tests, she told the Merrell Co. in May of 1961 that she suspected thalidomide might have some effect upon unborn children.

Six months passed. Then, in November, 1961, a German scientist reported at a medical meeting that there were strong indications that thalidomide was causing a significant increase in the number of deformed babies.

The drug was withdrawn from the German market and, in December, 1961, the Merrell Co. notified American doctors who were testing the drug of the German reports. It requested doctors not to use the drug on women of child-bearing age.

Finally, in March, 1962, the American pharmaceutical company withdrew thalidomide from experimental use in this country.

Though the most widespread tragedy resulting from thalidomide was felt abroad, America had had a close call. A report later issued by the FDA indicated that no deformities had resulted from thalidomide tested on patients in this country. President John F. Kennedy seemed to express the relief of the whole country when he hung a gold medal around Dr. Kelsey's neck in August, 1962, and thanked her for sparing the nation "this human tragedy."

Suddenly, everyone—for a time, anyway—was aware of the danger of improperly tested drugs.

One of the groups looking into this subject was a

Senate Government Operations subcommittee. Dr. Kelsey testified that the American manufacturer of thalidomide had been "very anxious" to obtain approval of the drug and, while its application was still pending, it had sent representatives to see her "quite often."

Senator Estes Kefauver, the Tennessee Democrat, wasn't so polite in describing these visits of Merrell representatives to Dr. Kelsy. He termed these social calls "high-handed pressure."

The company denied all. But Kefauver went on to score almost everyone concerned. He charged, for one thing, that the deforming effect of thalidomide could have been foreseen if the drug had been tested on rabbits and guinea pigs before it was distributed for human use.

He said an examination of the FDA's files on the drug showed that the manufacturer had limited its testing of thalidomide to rats and mice.

"The horror could have been averted," Kefauver said.

The "horror" of which he spoke was sometimes reduced to cold statistics. Some of these were released by Great Britain, which reported on 390 British mothers who had taken thalidomide while they were pregnant. Of the 390 infants, only 302 remained alive. And of the 302 living infants, 282 were deformed.

Ironically, the most famous case involving an American mother who had taken thalidomide obtained overseas was focused, not on a deformed infant, but upon the woman's determination not to give birth to a medical monster. Mrs. Robert Finkbine, an attractive hostess for a children's television program in Phoenix, Arizona, had inadvertently taken the drug and sought

an abortion rather than run the risk of giving birth to a deformed child.

Such an operation is not legal in this country. In her native Arzona, for example, an abortion was permitted only if it would save the life of the mother.

Braving a barrage of lurid headlines, Mrs. Finkbine traveled to Sweden, seeking a legal abortion. There she underwent the operation after a panel of the Royal Swedish Medical Board granted her request on grounds that it was necessary for her "mental health."

Mrs. Finkbine's fears had been well grounded. This 30-year-old mother of four healthy children was informed that the aborted fetus had been deformed, just as she had feared.

The thalidomide scandal quickly produced a tighter Administration drug-control bill. Its uproar also produced indications that not every drug company and public official had been as concerned about the possible dangers involved in drugs as they might have been.

The new bill provided for tighter factory inspections. It required drug manufacturers to keep records and report on adverse effects from use of their new drugs. It also extended the period of time in which the government could study a new drug application. To any critic of the industry, these proposals might seem reasonable enough.

But many of these same proposals had already been included in a bill which Kefauver—the drug manufacturers' one-man anathema—had tried in vain to get through a Senate committee some time earlier. The bill had been watered down, causing Kefauver to complain that, in its altered form, it was but "a mere shadow of itself."

Kefauver became so riled he took to the Senate floor

to charge that amendments had been agreed upon at a secret meeting.

Who participated in this meeting? Well, if the Senator had his facts straight, there were three fellow Senators attending—along with officials of the Department of Health, Education and Welfare.

Kefauver's accusations met denials at every turn—as they almost always did during his long career as a rackets investigator. But whether such a meeting was held, at this point in our history, is almost beside the point. The real question Americans should ask themselves is whether an industry which has life-or-death power over the patient is being policed sufficiently to protect the nation's health.

This question has, from time to time, occurred to the FSA. Not too long ago it said that it was looking int cases of rigged clinical research. After being put through this phony "research," drugs which had been improperly or inadequately tested were released for public consumption.

At the time, K. L. Milstead, the FDA's deputy director, outlined two types of rigged research employed by some drug manufacturers. In one, he said, an unscrupulous physician receives a substantial fee, supposedly for conducting clinical tests of a new drug. Actually, he doesn't test the drug but merely submits a test report designed to show predetermined results.

A variation of this game of Russian roulette—also involving the health of unsuspecting patients—introduces us to the "professional research quack." Milstead described the "scientific" role the latter plays in modern medicine:

"He makes a few uncontrolled observations on a few of his patients to whom he gives the product and then

permits the promoters to claim in their advertising and promotion that the product has been clinically tested."

The new drug may be a cure, of course. But for some patients, it could be a killer.

CHAPTER SIX

WHO POLICES THE HEALTH INDUSTRY?

On a day in April, 1955, church bells chimed joyously throughout the nation. The occasion wasn't a religious holiday. Nor did the pealing bells signal the end of bloody warfare.

The ringing of the bells did mark the end of one of mankind's longest battles against disease—waged against a mysterious malady which had left a toll of uncounted dead. Many of its victims who survived were crippled for life. And the most cruel aspect of this invisible maimer was that, for its helpless targets, it most often struck down innocent young children.

Its name, of course, was poliomyelitis—commonly known, because of its favoritism toward children, as infantile paralysis.

Earlier in 1955, news had spread that laboratory

experiments conducted under Dr. Jonas Salk had resulted in a vaccine that might be used to prevent this disease. But the public's immediate reaction of overwhelming joy had been tempered by word that the vaccine was still undergoing final tests. Skeptics further dampened the enthusiasm by posing at least two serious questions concerning the vaccine.

First of all, the vaccine contained inactivated viruses of the kind that caused polio itself. One question was: Could an inactivated—or "dead"—polio virus stimulate the human body to produce the necessary antibodies in the blood-stream to combat a real attack of polio?

Another question was even more vital. If the polio virus introduced artificially into a child's body by means of the vaccine was truly inactivated, or dead, fine. But what would happen if a virus, believed to be dead, was only temporarily "knocked out." Suppose this moribund virus somehow slipped through the laboratory procedure, found its way into polio vaccine and, after being injected into the body of a patient, "woke up?" Such a possibility obviously could have grave consequences.

But all public doubt about the new vaccine was dispelled on April 2, 1955. The U. S. Public Health Service announced at that time that the vaccine had been found to be "safe, effective and potent." Mothers reached for their children, doctors reached for their hypodermic syringes, and church sextons reached for their bell ropes. Large inoculation programs aimed at immunizing the children of entire cities were planned.

The unmitigated joy was short-lived, however. Within two weeks came reports that a number of children had been stricken with polio almost immediately after

receiving the Salk shots. In these cases, the skeptics' worst fears had come true.

There is no doubt whatsoever that the Salk vaccine prevented a large number of potential patients from being stricken with polio. As the always cautious *Encyclopaedia Britannica* puts it: "(The Salk type vaccine) was employed throughout the world beginning in 1955 and it greatly reduced the incidence of paralytic poliomyelitis where used adequately."

But at least one expert in the field remained unconvinced that the vaccine, in return for protecting the majority of those inoculated, had a "right" to claim a lesser number of "sacrificial victims." Nor was he convinced that all those who supervised the first polio inoculation programs in this country were entirely blameless in hurrying through their jobs. This "doubting Thomas" is a British doctor, John Rowan Wilson.

Dr. Wilson can't be accused of sensationalizing on the polio vaccine issue. His book, *Margin of Safety,* wasn't published in this country until 1963, eight years after the events of 1955 had ceased being infused with emotion.

In *Margin of Safety,* Dr. Wilson takes a critical look at the polio vaccine triumph and its sudden tragic turn. "The truth is that there had been mistakes everywhere," he writes.

Dr. Wilson's book title stems from his belief that Salk miscalculated the margin of safety necessary in killing viruses which went into the vaccine. But he doesn't blame Salk alone.

The U.S. Public Health Service, he says, had not set sufficiently rigid standards for the production of vaccine.

Dr. Wilson does not spare even the National Foun-

dation for Infantile Paralysis, now the National Foundation and generally regarded as a sacrosant organization. The doctor claims that, with its touching poster children and marching mothers, the foundation turned what should have been a scientific investigation into a melodrama. Perhaps most significantly of all, he says:

"The foundation stepped well outside its legitimate fold . . . and (took) over a vast experiment in public health which should have been a government responsibility."

When Dr. Wilson's book appeared, the Foundation had no official comment. But sympathetic observers indignantly argued that, without the Foundation, there would have been no polio vaccine in 1955.

In view of the government's notable lack of leadership in areas of public health, particularly in research, their point can hardly be disputed. But should Americans be satisfied with the role their government has played in public health? We must note that in many cases this role is a dualistic one, leaving the government open to charges of committing sins both of omission and of commission.

In no case was this demonstrated more clearly than in its inept fight against the "cancer suppressant," Krebiozen. During a nine-month trial, which ended in January, 1966, the government attempted to prove that Krebiozen had never existed, that ampules marked "Krebiozen" had contained only mineral oil, and that for 15 years the defendants had perpetrated a "gigantic hoax" on desperate cancer victims.

The trial ended with all defendants being acquitted. These included Dr. Andrew C. Ivy, former vice president of the University of Illinois; F. P. Phillips, a Chicago physician; Marko Durovic, a former judge in

Yugoslavia, and Dr. Stevan Durovic, discoverer and principal promoter of Krebiozen.

Ivy, a noted physiologist, had advocated that the government clinically test Krebiozen as a possible cancer suppressant ever since Dr. Durovic first brought him a sample of it from Argentina, back in 1949.

The government took a dim view of Krebiozen from the outset. Finally, almost two decades after Krebiozen had been introduced in this country, it got around to indicting some of those working with Krebiozen. Ivy was indicated on 37 counts. These included mail fraud, mislabeling Krebiozen, introducing it into interstate commerce without FDA approval, hindering the government's long investigation into the substance and lying to the government about Krebiozen's value.

Many cancer victims and their families swore by Krebiozen. When the defendants were acquitted, the verdict was greeted by shouts of joy. Some women cancer patients wept with satisfaction.

The trial was one of the longest of its kind ever held. The government's preparation and presentation of the case had taken more than three years and had cost the taxpayer something like a half million dollars. This is the same amount of money, incidentally, which the government claimed the defendants made from the substance each year.

The man in the street may be excused if developments leading to the Krebiozen trial and the trial's outcome left him a little confused. Here was the government saying a medical fraud had been going on for 15 years. Here was the government, at last ready to do something about it. Here it was, spending a vast amount of its time and the public's money, trying to stop the Krebiozen promoters dead in their tracks. Yet

it couldn't prove its contentions about Krebiozen and its backers in a court of law.

Where did that leave the families of cancer patients, particularly those who had been wondering if perhaps they should try Krebiozen?

Let's look at other grave questions which, in the absence of adequate law or its enforcement, sick persons must often answer unassisted.

In few fields, now that Prohibition is past, is government on all levels so inffectual as when it gives battle to bootleggers, not of illegal alcohol, but of unethical medicine.

A recent magazine advertisement read:

"Dr. Abn Donahji, Yogi Healer and Clairvoyant Reader, will sove your problems."

Two of those who read this ad were a deaf-mute couple in Atlanta. The wife was suffering from cancer. Hopefully, they wrote Dr. Abn Donahji.

Of course, he replied, he could cure the woman of cancer. It might take a little time. But all that was required in the meantime was a $5 weekly "donation."

The couple began making weekly payments. When they finally asked the "doctor" when they could expect some results, he replied, "The vibrations are building up favorably."

Within a year, the woman died.

Postal inspectors discovered that Dr. Abn Donahji had been given the name of Donald Van Dyke shortly after he was born in Des Moines, Iowa. A former automobile assembly-line worker, he had hit upon the idea of becoming a "healer" while in Los Angeles, one of the world's capitals of faddism and fakery.

Van Dyke had changed his name, stuck a turban on his head and studied enough occult books to pick up a

convincing vocabulary. He had made an estimated $400,000 by offering advice such as he'd given the Atlanta couple and by selling copper bracelets imbued with "health-giving properties." He'd sold these trinkets for as much as $76 each after buying them wholesale for 37½ cents. Van Dyke's health "business" was so good that he was living in a comfortable mansion and driving round in a gold Cadillac before he was arrested and jailed.

In the absence of local laws or enforcement, there is little the federal government can do in such cases except try the quacks on mail fraud charges. The penalty for this crime must be considered relatively light when it's taken into account how much needless financial sacrifice and frustrated hope these phony practitioners wring from their victims.

The human misery caused by mail-order quackery is far more widespread than many persons realize. The Arthritis Foundation estimates that arthritis quackery alone is a $300-million yearly enterprise, a large part of it conducted by mail order.

Not all health-by-mail operations can be labeled as fraudulent, though almost all can be considered borderline cases. For example, there's the mail-order "health examination." One branch of this business offers urinalyses by mail.

A typical plan offers the mail-order "patient" a year's service for $15. This service includes four urinalysis reports based on specimens of urine which the "patient" sends by mail. An advertisement for one such mail-order concern describes the service in glowing terms:

"Keeping You Healthy is Our Business . . . a systematic preventive health-care program that can mean

less suffering, less hospitalization, less job-hours lost, and peace of mind because of better health."

At fault here is that a urinalysis is only one aspect of a complete physical checkup. The American Medical Association points out that such a mail-order program could create a false sense of security in persons who are ill from a disease whose symptoms don't appear in a test of the urine.

At least one of these urinalysis-by-mail operations has been caught engaging in outright fraud. An outfit calling itself Science Laboratories, in Flagstaff, Arizona, not only faked urine-test reports to indicate that patients were ridden with various diseases. It further played doctor by recommending that the ailments be treated with vitamin food supplements obtained by mail from another company in Cedar Rapids, Iowa.

It should come as no great surprise to an intelligent reader that the two mail-order firms were involved in a kickback operation. They had made approximately $11-million—$3-million paid for phony urinalysis reports and $8-million from vitamins and other food supplements. Three men admitted their guilt. Their punishment? Two were fined $6,000 each and a third drew a three-year term.

Whether health hazards are offered by untested drugs, faulty vaccine, dubious practices or downright quackery, the public is offered scant protection by law. The comparatively few frauds who are apprehended are allowed by present statutes to get away with hardly more than a slap on the wrist.

Even granting that the federal government's concern for the health of its citizens should be secondary to its race for the moon—a dubious premise at best—shouldn't legislation protect Americans of all ages from

such tragic mistakes as faulty batches of vaccine and further shield them from the greed of phony "doctors?"

Evidence abounds that, even under modern law, an American seeking to maintain or improve the health of himself or his family is often forced to observe the ancient admonition of *caveat emptor*—"let the buyer beware."

This is a harsh rule, outmoded in almost every enterprise today, including the once notorious used-car business. But for the most part, that old saying still holds true in the sometimes shady but thriving "health industry."

"To live by medicine is to live horribly."
—Carl Linnaeus *(Diaeta Naturalis)*

CHAPTER SEVEN

NEW HEALTH MENACE: BIRTH-CONTROL PILLS

One medical danger for which even the public can share the blame is the tremendous use of birth-control pills.

An estimated six million American women are on the pills, and five million women in other countries are taking them. Yet relatively little is known of their real effects. Case after case illustrates the suspicion voiced by some experts that the pill can be hazardous.

A Columbus, Ohio, doctor is convinced that his 14-year-old niece died unexpectedly because of the pill.

A Washington, D.C., gynecologist says he has "clinical proof" that many women suffer hemorrhaging because of the pill.

A British neurologist says he can't draw any hard and fast conclusions—"but we are seeing more cases of

stroke in young women. And most of them are on the pill."

Why does the pill continue to sell despite the widely debated controversy? Because women's demands for it are so strong that their own doctors—and possibly even the federal government—wouldn't dare to outlaw it.

If women wish to ask their doctor for the pill—or even to demand that he give them a prescription for it, as thousands of them do—they at least should know the facts about it. And one of the most disturbing of these is that so many facts about it remain unknown.

The skimpy nature of this knowledge was underscored in August, 1966, when the Food and Drug Administration admitted some of the frightening things that weren't known about the pill. The FDA said there was *no way of knowing* whether the pill might increase the risk of cancer, strokes, emotional illness, blood clots, visual disturbances, liver disease, diabetes or malfunctioning of the thyroid, pituitary or adrenal glands.

Nor, said the report, was there any way of knowing how the pills might affect future pregnancy problems.

The advisory committee which prepared the report for the FDA then did what some observers thought was a most curious thing. While saying on one hand that it couldn't guarantee the pill's safety, the committee recommended that the FDA lift its four-year limitation on the length of time that women should take the pill.

After this remarkable inconsistency on the part of the committee, it's now legally possible for a doctor to prescribe the pill to a woman, not just for four years, but for her entire reproductive life. This means that

many women might legally be subjected to unknown effects of the pill for more than 30 years.

Why did the committee recommend removing the time-limit on the use of the pill? Did it feel that, even though proof was lacking, the pill was perfectly safe? Hardly. One of the most—if not *the* most—important considerations appears to have been the conviction that women would take the pill, whatever the committee recommended.

This view was indicated by Dr. Louis Hellman, professor of obstetrics and gynecology at the State University of New York. Dr. Hellman, who was chairman of the advisory committee, said:

"We knew the four-year-limit was unenforceable, like Prohibition. We thought it wiser to remove it than to let a lot of black market distribution develop. That's what would have happened—bootlegging the pill.

"There's no way to stop women from getting it. At least if they get it legally, we can hope their doctors are making them come in for regular checkups."

Dr. Hellman cited a personal experience to suggest that the committee was correct in assuming that many women would seek the pill regardless of medical advice. At the time of this episode, the doctor was working on the report whose contents were still top secret.

"My own daughter-in-law said to me, 'I don't want to pry into your confidential work,' " said Dr. Hellman, " 'but if your committee is going to suggest banning the sale of the pill, I want to get a lifetime supply before your report comes out.' "

A Topeka, Kansas, gynecologist has even stronger proof that many women would seek the pill regardless of consequences. Dr. Richard Merkel says, "I tell them bluntly, 'You may go blind if you use this drug.'

"But then they tell me that their girl friends all use the pill. It's a status thing. It's the modern, fashionable method. They'd rather risk blindness, possible damage to their future children—anything—to avoid the scorn of their girl friends.

"They say to me, 'O.K., Doctor. You've gone through the warning bit. Now give me my prescription.'

"So I say, 'Here it is. But don't come back and blame me if you get into serious trouble.' "

Some women have taken the pill and noted no unpleasant side effects for several months. Then they've undergone terrifying experiences, leaving them to wonder just how safe the pill really is.

One Bethesda, Maryland, mother who asked that her name be withheld reported:

"I felt I had found the perfect answer to one of married woman's most pressing problems. The pill lived up to its advance billing—easy, safe, dependable. Three months later, the picture changed completely.

"I began to have stabbing pains in my chest and difficulty with breathing. I finally went to my family doctor, who gave me a thorough physical and scheduled me into the hospital the next day. That night as I got up to get a codeine tablet, I had a massive seizure of pain throughout my chest. It was so excruciating, I screamed, 'I'm dying!'

"Twenty minutes later I was in the hospital getting injections of anticoagulants. I was one of the lucky ones. I had a massive blood clot in my lungs, and I was fortunate enough to have it diagnosed in time. I had to spend two weeks in the hospital and to continue on anticoagulants for seven weeks.

"I think it's interesting that the interns at the hospital asked immediately whether I had been taking oral contraceptives. Of the various doctors who cared for me, however, only one, a chest specialist who was called in as a consultant, agreed that there might be a relationship between the pill and my pulmonary embolism.

"He said that he had seen more women entering the hospital in my condition in the last few years than he had throughout many years of medical practice before the pill was invented."

Such talk among doctors is frequently heard—but only when they are talking in confidence to fellow doctors. One reason many of them publicly turn their head from the possible dangers of birth control pills is the possibility of malpractice suits. For has the pill been tested exhaustively and found to be completely safe?

A common testimony to the pill is that it was tested on thousands of women in Puerto Rico as long as 12 years ago. These tests, in fact, were the basis upon which the FDA released the first pills for general use. Proponents of the pill have cited the work of Drs. Gregory Pincus, Celso-Ramon Garcia and Edris Rice-Wray.

This work was discussed in a recent article in *Ladies' Home Journal* titled "The Terrible Trouble with the Birth-Control Pills." The article, by Louis R. Chevalier and Leonard Cohen, pointed out that these much-cited studies are not in any sense scientifically controlled. These reporters wrote:

"The Family Planning Association in Puerto Rico operates several birth-control clinics. In 1956, when the tests were begun at the Rio Piedras Clinic, the researchers were solely interested in whether the pills

would prevent pregnancy. They were not even giving the women physical examinations. The following year they began to examine them, and now they are insisting on annual examinations for every woman who receives the pills.

"For the most part, these are low-income women with minimal education. They drift in and out of the program. In one group of 811 women, 556 dropped out in the first year. The turnover was 100 per cent by the third year. So no systematic large-scale follow-up has been possible."

Chevalier and Cohen quote Dr. Pincus as saying, "We keep track of them the best we can. We try to get the dropouts to come back for examinations. Perhaps we get 20 per cent of them back."

"Dr. Pincus says proudly that there have been no cases of thrombophlebitis, strokes, coronaries or diabetes among the clinic patients—at least none that he knows about," say Chevalier and Cohen. But they add these interesting observations about the non-controlled studies:

—A small number of patients fail to start menstruating again after they stop taking the pill.

—A large number of them have abnormal amounts of cholesterol in their blood.

—A large number of them have impaired liver functioning.

—A large number have anemia.

Dr. Pincus, on the other hand, points out that the nutrition of many of these women is poor and that they are beset by the infections of a number of parasitic diseases. These factors could be responsible for the physical conditions noted among many of those taking the pill.

Maybe.

But at least we've been given an insight into some claims based on the experiences of "thousands of Puerto Rican women."

In 1962, the public had been made newly aware of the possible danger of drugs. The thalidomide scandal was still in the air, and there was talk that the FDA might order birth control pills off the market.

G. D. Searle and Co., the manufacturer of Enovid, the first of the birth control pills, called a conference to consider the pill's safety.

Attending the meeting were thirty scientists. They met at the American Medical Association's headquarters, in Chicago. The chairman of the meeting was Dr. Michael DeBakey, a pioneer heart surgeon from Houston.

Among the millions of women who had taken Enovid pills, 132 had been reported to have suffered severe blood clots. Of these, eleven had died.

The Searle Co. made its records of these cases available to the scientists to study. One of those who questioned the possible effects of the pills was Dr. Christopher Tietze. He is director of research for the National Committee on Maternal Health. He told the meeting:

"We have an apparent incidence of about 13 deaths per million women. The number of reported cases among users of Enovid is, therefore, almost twice as high as the number of expected cases. Gentlemen, I am troubled by the number of fatal cases."

Not all the doctors present sided with Dr. Tietze. After they had discussed the question for a day, DeBakey suggested that those present should endorse the

idea that "up to the present time there is no evidence to suggest a causal relationship" between the birth control pills and thromboembolism—a blood clot which moves through the blood vessels. The proposed resolution added, however, that there should be further studies of this possibility.

Objecting to this resolution was Dr. Stanford Wessler, assistant professor of medicine at Harvard Medical School.

"The point that disturbs me," he said, "is that a decision is being based on a statistical basis, yet the pertinent statistics are not available.

"We may be condoning the use of an entirely elective drug by healthy young women without adequate evidence. This is a sobering responsibility."

But the resolution passed. And the scientific conference was declared at an end.

Chevalier and Cohen conclude:

"The story of the Searle conference is important because it illustrates so clearly how thin and make-shift the so-called scientific evaluation of the pill has been. The 30 scientists argued for a day over figures that everyone knew were only guesses and estimates.

"These guesses and estimates could be juggled to provide death rates ranging from 13 per million down to one per million.

"Yet scientists passed a reassuring resolution, and catastrophe for G. D. Searle and the pill proponents was averted."

The tremendous sale of birth control pills indicates that many women would rather risk illness or death than be considered old-fashioned.

Meanwhile, the government has had the temerity to

lock horns with the powerful tobacco industry—though some observers regard this tilt mainly as an exercise in "shadow boxing." But it surrenders completely rather than fight the dangers inherent in birth control pills.

"Our body is a watch, intended to go for a given time. The watchmaker cannot open it, and must work at random. For once that he relieves or assists it by his crooked instruments, he injures it ten times, and at last destroys it."
—Napoleon Bonaparte *(To. Dr. Antommarchi)*

CHAPTER EIGHT

HOSPITALS: ENTER AT YOUR PERIL

"If I were sick and had to go to a hospital, there are only a few in the country I'd trust myself to."

If the speaker were a mere patient, it might indicate he was a neurotic with an exaggerated fear of hospitals. But the one making that observation is Dr. John H. Knowles, a leading hospital authority. He is general director of what may well be America's best hospital, Massachusetts General in Boston.

Unlike many European hospitals, which are manned by full-time specialists, most of those in America are run, for the most part, by medical amateurs.

Oh, the doctor will assure his patient that he maintains full control of the case. But in most instances, this simply is not true. Lucky, indeed, is the patient who even sees his doctor occasionally during his hospital stay. For most patients, once they enter the hospital door or leave the operating room, are turned over to

the hospital's nurses, interns and resident physicians. And the latter in most institutions have far more work than they can adequately perform.

This places much of the responsibility for a hospital patient's well-being directly upon the shoulders of the intern. He's a doctor who is not even licensed to practice medicine.

The life of the intern is a busy one, presenting its own dangers to some patients. A recent best-selling book, *Intern,* by "Doctor X," published by Harper and Row, deals at some length with this aspect of hazards found in hospitals. Speaking of hospital internship, the author says:

" . . . the cardinal law of 'Primum non nocere'—'First, do no harm'—which has always guided the practicing physician is necessarily suspended during this critical year of a doctor's training. He learns most about medicine in this year than in all the other years combined, and he learns, for the most part, by committing a long succession of colossal blunders and then having them corrected (if possible) by the experienced doctors looking over his shoulder.

"Many times the intern *will* do harm. Many times he *will* make things worse instead of better."

It's a high price the patient must pay, serving as guinea pig for a doctor's on-the-job training.

In their book *Sickness and Society,* Dr. Raymond S. Duff and Professor August B. Hollingshead give several examples of hospital patients who had every right to be terrified—even when they were "lucky" enough to be in the hands of so-called trained experts.

Here's what being in a hospital meant to one 40-year-old woman patient:

She lay alone, strapped to a stretcher cart outside an

operating room for an hour and fifteen minutes. She saw another woman wheeled out of the operating room with blood-stained bandages on her chest. The waiting patient felt panic. The nurses striding rapidly down the corridors ignored her.

Finally, she was wheeled into the operating room. Under the bright lights of the operating table the surgeon looked at her curiously. "The records seem to be missing," he confessed. "We should have an internal examination. How long have you had this?"

Already terrified, the woman replied, "Two years."

"Which side?" asked the anesthesiologist.

"Left side," she said, trying to remain calm.

The surgeon noted a scar on her abdomen and asked, "Who operated on your gallbladder?"

Finally, the woman broke down and shouted in desperation. "It wasn't my gallbladder. It was my ulcers!"

Dr. Duff explains that when part of a patient's record is missing, such questions are frequently asked to insure the doctor against error. But from the patient's viewpoint, of course, such a last-minute "third degree" hardly reassures him that he's in knowing hands. To all but the most steel-nerved patients, such an ordeal can be traumatic.

Genuine mix-ups happen fairly frequently in many hospitals. One woman with a deathly fear of hypodermic needles had been admitted after her doctor had assured her that there would be no need for such treatment. She was merely to remain there for a day for a series of X-rays.

First of all, she was to be given a dose of castor oil in preparation for the examination. The nurse gave the castor oil to the wrong patient.

For the patient who received this unexpected dividend, this meant unpleasant—and unnecessary—consequences. For the woman who didn't receive the needed medicine, it meant another day in the hospital.

The next night, she was wakened with a nurse pulling aside her bedcovers. Poised in the nurses's hand was a hypodermic syringe with a long needle.

Near hysteria, the patient cried that her doctor had promised that she wouldn't have to receive an injection of any sort. The nurse was determined. She was merely following orders, she explained.

Finally, the nurse asked the crying patient her name.

"Oh, that explains it," she said.

The injection had been prepared for another patient.

So many mix-ups of this sort are detected in hospitals that one can only wonder how many more occur with no one the wiser. If this patient hadn't been so afraid of hypodermic needles, she might well have been injected with—what?

What possible effect might this unknown substance have had upon her particular condition? Suppose she were allergic to it. Mightn't she have become just another of those patients who, in seeming good health, sometimes mysteriously die shortly after being admitted to a hospital?

One hospital patient who did wind up as a vital statistic might have been alive today if his nurses had been as adamant in following their orders as was the nurse just mentioned. This patient was a prosperous businessman. He had made all arrangements to make his recovery from gallbladder surgery as painless as possible. This had included his hiring of private-duty nurses.

Since the patient himself provides for her pay check,

this type of nurse is, as a rule, generally anxious to please. But in some cases this can be bad for the patient. It can even be fatal.

The businessman, for example, was used to giving orders, not taking them. In pain after the operation, he refused to obey the doctor's orders—as relayed through the nurses—that he start walking around.

He began quarreling with his nurses, insisting on constant attention. The nurses soon learned not to argue. To keep their patient quiet, they began giving him large doses of narcotics and barbiturates. Common practice gives registered nurses considerable latitude in such delicate matters.

Four days after his surgery, the patient developed a cough. Three hours later, he died. He'd developed a pulmonary embolism.

Doctors involved in this case were unwilling to pin the blame on the nurses—though they were aware that the embolism could have been caused by excessive use of narcotics combined with a failure of the patient to ambulate. But, after all, nurses, too, are considered part of the self-protective medical "fraternity." And "outsiders" just wouldn't understand such a tragic "goof."

We can be sure that the doctors in this case privately castigated the nurses involved for failing to follow orders. Of course, a lot of good this did the dead patient!

Misplaced attention such as these nurses displayed is, of course, a form of oversolicitude. Far more common in most hospitals is lack of needed attention. The author himself can testify to an extreme example of the latter. It occurred in the spring of 1968 in a leading hospital in New York City.

An elderly man was admitted and placed in a room with three younger patients. Throughout the day and night he kept moaning, "I'm dying. I'm dying." A young intern or resident visited him infrequently to ask him what the trouble was. The old man didn't answer. He appeared too concerned with his pains to reply.

Some of the nurses on the floor began treating the old man as a joke. "He's senile," one explained to another patient.

Few patients on that end of the floor got much sleep those nights as the old man kept moaning that he was dying. But the fourth morning he lapsed into silence. He'd been right. He had been dying. And he died with no more solicitude or attention than an occasional how-do-you-do.

At last, however, the old man's roommates and other nearby patients could get some sleep. The hospital hadn't been overly considerate of them, either.

To die alone and unattended might be the wish of a number of hospital ward patients. A ward patient is unfortunate, indeed, if he has a disease which doctors consider "interesting"—particularly if he's bedded in a hospital attached to a medical school.

Long after his case has been diagnosed, he's apt to be the target of numerous unnecessary—and sometimes painful—tests, just to see if the medical students can correctly guess what's ailing him.

There's little such a patient can do to fend off this unwanted avalanche of attention from curious young medicos. He's lucky by nature and constitutionally sound if he recovers from their endless probing and blood-letting—which his body must now fight along with the disease.

Most ward patients, however, hold no such fascination for young doctors. They tend to view most patients in this category with contempt. This is reflected in the secret vocabulary employed among these doctors and hospital attendants. To them, the ward is known as "the zoo."

An "uninteresting" ward case is known as a "turkey." Elderly or difficult patients are "crocks." A resident who admits too many "turkeys" or "crocks" to a ward is frowned upon because he's a "sieve." But if he's good at turning away such cases, he's looked up to as a "rock."

A hospital patient who escapes too much or too little attention is not necessarily blessed. He can die from just the right amount of inept attention. Dr. Martin Cherkasky, head of New York's Montefiore Hospital, would seem to agree that poorly qualified doctors are still a big hazard on the hospital scene.

"Every day," Cherkasky says, "general practitioners still take out bowels, gallbladders and uteruses" in many of our nation's hospitals.

Surveys have indicated that in Michigan and Oklahoma, for instance, as much as three-quarters of all surgery is performed by surgeons with no specialty training.

Is treatment by a qualified specialist important in the case of a disease or disorder serious enough to warrant hospital care?

Cherkasky, for one, thinks so. To back up his opinion he offers this stark statistic: "In the hands of a gynecologist, a woman with cancer of the cervix has an 80 per cent chance of a cure. In the hands of someone who is not specially trained, her chances are only 50 per cent.

In contrast to the free-wheeling practices of many

U.S. hospitals, those in some European countries are tightly controlled, indeed. Most European hospitals are staffed only by fully qualified specialists. In nations like England, West Germany and Sweden, a family doctor "loses" his patient at the hospital door—and regains him only when he's released.

The U.S. system has both its virtues and faults. As a survey by the *Ladies' Home Journal* in 1967 put it:

"On the plus side, the wider extension of hospital privileges has tended to upgrade all doctors, including general practitioners, by keeping them abreast of scientific developments. The European general practitioner often feels left out of medicine's advances. But we have exposed the average patient to a more capricious range in quality."

One danger always lurking in any hospital is the possibility of infection. For some patients, if their original complaint or the bumbling of doctors or nurses doesn't get them, infection will.

One leading hospital authority admits: "Staphylococcus disease (a form of infection) is endemic in our hospitals."

Dr. A. T. Toden, of the British Ministry of Health, was even more emphatic in an article recently appearing in the *British Medical Journal*. "Those who say we have no problem of sepsis (poisoning by bacteria infection) in our hospitals have never taken the trouble to look into the matter," he said.

One authority estimates that the average hospital patient runs a 20 to 50 per cent chance of acquiring infection from the hospital's environment. Some patients who did acquire such infection recently included:

—Five infants who died of dysentery in a Kansas hospital infection epidemic.

—Two infants in Florida who died of a bacterial blood poisoning they had developed in a hospital nursery.

—A New Jersey man who died of an infection contracted from his wife, who picked it up in a hospital from her own baby.

—Two cancer patients in one of New York's leading hospitals who died, not of the disease for which they were being treated, but of infection.

Those who contract infection in a hospital and escape with their lives sometimes pay steep prices for somebody else's mistake or inattention to duty. Dr. Ralph Adams, of Boston University and the Massachusetts Memorial Hospital, estimates that major infection "costs somebody $3,000 per case."

If a patient can't prove that subsequent infection isn't just an outgrowth of his own disease, chances are that he'll end up paying for it himself. In other cases—such as those of ward patients—the taxpayer will probably pay for at least a large share of the expenses.

Even so, as financially punished as he may be by all this, the taxpayer who can manage to remain outside a hospital is fortunate in the extreme. To enter a hospital is to do so at your own risk.*

*Following is a list of the top 10 hospitals in America as chosen by a jury of experts and published in the February, 1967, issue of *Ladies' Home Journal*. The panel was comprised of Dr. Lester Breslow, Director of Public Health, California; Ray Brown, Duke University; George Bugbee, University of Chicago; Dr. Martin Cherkasky, director, Montefiore Hospital; Dr. Dean Clark, director, Medical and Hospital Administration, Graduate School of Public Health, University of Pittsburgh; Dr. John Knowles, general director, Massachusetts General Hospital; Dr. Charles Letourneau, editor and hospital consultant; Dr. David Littauer, executive director, Cedars Medical Center; Matthew McNulty, Jr., dean, University of Alabama Medical Center; and Dr. Russell Nelson, president, the John Hopkins Hospital.

THE TOP TEN

1. Massachusetts General, Boston
2. Johns Hopkins, Baltimore
3. University of Chicago, Chicago
4. Columbia-Presbyterian, New York
5. New York Hospital, New York
6. (tied) Barnes, St. Louis
   Henry Ford, Detroit
7. Mount Sinai, New York
8. St. Mary's, Rochester, Minnesota
9. (tied) Palo Alto-Stanford, Palo Alto, California
   Yale-New Haven, New Haven, Conneticut
10. (tied) University Hospital, Ann Arbor, Michigan
    University of Minnesota Hospital, Minneapolis, Minnesota

OTHER OUTSTANDING HOSPITALS

The following hospitals were chosen by the *Journal's* panel of experts as ranking right behind the nation's best in this order:

Duke Hospital, Durham, North Carolina
Montefiore Hospital, New York
University Hospitals, Cleveland
Hartford Hospital, Hartford, Conneticut
Michael Reese, Chicago
Cedars-Sinai, Los Angeles
Rochester Methodist Hospital, Rochester, Minnesota

Tied:

Methodist Hospital, Houston
Peter Bent Brigham, Boston
Strong Memorial Hospital of the University of Rochester, Rochester, New York
Hospital of the University of Pennsylvania, Philadelphia

Tied:

University Hospital, Seattle
University of California Medical Center, San Francisco
Presbyterian-St. Luke's, Chicago

Tied:

University Hospital and Hillman Clinic, Birmingham, Alabama
University Hospitals, Madison, Wisconsin
Cleveland Clinic Hospital
New York University Medical Center, New York
Vanderbilt University Hospital, Nashville
Baylor University Medical Center, Dallas
Beth Israel Hospital, Boston

Many of the panelists who chose these hospitals did not share Dr. Knowles' degree of selectivity by agreeing that they would entrust their lives to only "a few" hospitals. But it's noteworthy that not a single member of this well-qualified panel was willing to name more than 175 hospitals as acceptable.

As the *Journal* put it: "This means that *at best* only two to three per cent of our hospitals provide the kind of care these men want for themselves and their families."

Would you want any less for you and yours?

"Nearly all men die of their remedies,
and not of their illnesses."
—Jean Baptiste Moliere (*Le Malade Imaginaire*)

CHAPTER NINE

IS THIS OPERATION NECESSARY?

Many patients regard the man with the business-looking stethoscope around his neck as a modern god. But the doctor at times proves to be all too human.

Sometimes he's too ready to prescribe unproven drugs.

Sometimes he's too ready to operate.

Sometimes, when he does operate, he makes a horrible botch of the job. The patient is subjected to needless suffering, dies, or both.

Are all operations necessary?

Almost all authorities are agreed that they are not. How many operations are unnecessary is a matter for conjecture. Some medical experts believe as many as 75 per cent of the operations performed could be avoided, with no harm to the patient. Most believe the

number to be considerably smaller than that. But many concede that estimate is not outlandish.

Two reasons make it impossible to determine exactly how many surgical operations are unnecessary. First, it's obvious that an unscrupulous surgeon bent on removing a healthy organ or performing some other operating-room task for the large fee involved, rather than because his patient's health demands it, isn't going to broadcast that fact.

Virtually all hospitals discourage unnecessary operations by requiring a laboratory examination of tissue removed by surgery. These tests, which determine whether the tissue was diseased, indicate whether some operations—the removal of a gall bladder, for example—were necessary. But they are no sure indication for all operations. And many hospitals offer a means for a doctor to cheat the system, if he wishes. We'll discuss this situation a little later.

Second, many operations fall into the doubtful category. While some doctors might argue that a certain operation was necessary, others could be found who would argue—in private, with only fellow doctors listening, of course—that it wasn't.

"In hospitals where there is little control by examination of removed tissue after surgery, unnecessary operations can and do occur," reports the medical expert, Roul Tunley. "This is especially true of tonsillectomies, appendectomies and hysterectomies."

Tonsils are a favorite target of surgery. Statistics indicate that a number of tonsillectomies performed in this country are unnecessary. This type of operation accounts for between 6 and 7 per cent of all surgery performed in the United States. But in Sweden—where hospital doctors are salaried specialists and don't get

paid a fee for each operation—the figure runs between one-half and one per cent.

Routine circumcision for male infants in cases serving no religious purpose has become standard operating procedure with many doctors. The reasons the physicians offer for this practice range from the contention that it's hygienically useful to the bland assertion that it *may* help prevent cancer.

The latter argument isn't supported by statistics—either those figures dealing with the incidence of cancer of the penis or those concerned with cervical cancer among women married to uncircumcised vs. circumcised males. In fact, statistics for some tribes and peoples among whom circumcision is practiced extensively show a higher incidence of cancer than that found among some uncircumcised groups.

As for the argument that circumcision makes it easier to keep the male organ clean, one doctor has been quoted as saying that the ears, too, are hard to keep clean. But no one seriously advocates that infants' outer ears should be surgically removed at birth.

The most persuasive reason behind the increasing frequency of this "routine" operation is that it offers the obstetrician a comparatively simple justification for fattening his fee. It's one operation that isn't questioned by the operating room's "traffic cops" who are supposed to blow the whistle on unnecessary operations.

This policeman's job falls upon the Tissue Committee, which every reputable hospital includes in its administrative set-up. During an operation, removed tissue is immediately passed to the scrub nurse. She gives it to the circulating nurse, who drops it into a bottle of fixative, tags it and routes it to the pathology depart-

ment. No tissue is ever thrown away until after a pathologist makes his report.

Few operations are performed in which tissue is not removed. These relatively rare ones include those designed to repair some hernias, to clear obstructions in ducts and the intestines and to break up adhesions caused by previous operations. Neither is tell-tale tissue removed in such operations as the tying off of fallopian tubes to prevent pregnancy or the stitching of the uterus to a nearby support, to correct an "abnormal" position.

The surgeon who performs too many operations in which no tissue is removed faces the same unpleasant experience as one who performs too many operations in which removed tissue is reported by the pathologist to have been healthy. In either case, he's questioned by the Tissue Committee or the chief surgeon.

If a surgeon is thus challenged two or three times, his operating privileges at that hospital are jeopardized. Where, then, can the unscrupulous doctor get away with performing unnecessary operations?

In a number of private hospitals which don't have such a stringent system.

In *The Healers,** the author signing himself "Anonymous, M.D.," says:

"... The private hospital will tolerate hundreds of no-tissue-removed operations without a murmur of disbelief, thus making less work for the pathologist.

"... Few if any have a resident pathologist. They usually farm out their work to an underpaid man at a nearby voluntary or public hospital.

"This man is a real study in conflicts. He needs the money the private hospital pays him. He hasn't the

**The Healers,* 1967, G.P. Putnam's Sons.*

time to examine the tissue from his own hospital. And he suspects, or knows, that a lot of the tissue won't show any pathology. He also knows he won't be paid much longer once he starts rendering careful, honest pathology reports to the private hospital. . . ."

The anonymous author of this book, incidentally, is one who believes that the big majority of operations are unnecessary. What are his qualifications for this judgment? He says that he's an M.D., licensed to practice in several states; a diplomat of the American Boards of Obstetrics and Gynecology and a fellow of both the American College of Surgeons and the American College of Obstetricians and Gynecologists.

Having recited these credentials, he then tells us that, of all the operations performed in the United States, "more than 75 per cent are unnecessary."

In his book, *The Doctors,** Martin L. Gross says that probably nine out of ten tonsillectomies are unnecessary. And he cites figures indicating that a shocking number of appendectomies are unnecessary, too.

"In Baltimore," writes Gross, "Dr. J. Frederick Sparling of the Johns Hopkins Hospital surveyed 1,002 appendectomies in five hospitals, three accredited community institutions and two university hospitals. In the community hospitals less than half (49.2 per cent) of the appendectomies were found to have been necessary. Twenty-one per cent were patently unnecessary and the balance were 'doubtful.' The university institutions did better (67.3 per cent), but even one in three of their operations could not be labeled as necessary."

Another favorite pastime of surgeons, it seems, is the removal of the uterus. Each year approximately 359,000 hysterectomies are performed in the United

**The Doctors,* 1966, Random House.*

States. This means that removing the uterus and its trappings has become almost as popular with surgeons as performing appendectomies, which they execute at the rate of about 410,000 a year. When one considers that these statistics are for both males and females, with the males contributing nothing to the uterus collectors, it becomes apparent that the woman patient's uterus has become a more common trophy for the surgeon-hunter than her appendix.

This fact has led *GP* magazine to observe editorially:

"There is no avoiding the thought that some surgeons are too ready to remove the uterus. Sometimes this may be because, in all sincerity but without real justification, they expect too much of this operation. It has never sufficed as a method for relieving vague female ills. Other times, surgeons may do a hysterectomy purely for reasons of expediency.

"Then there is the woman-patient's part in the problem—her strange passivity or even willingness to sacrifice this part of her body. If the record for this operation is to be improved, hospital discipline and surgeons' and patients' education need reorientation."

Dr. James C. Doyle, a Los Angeles gynecologist, led a thorough survey of 6,248 hysterectomies performed in 35 hospitals in the area. A total of 39.3 per cent of these were listed as ones "that may be criticized."

No reason at all was found for 12.5 per cent of these operations.

Finally, in 24 per cent of the cases, those conducting the survey believed, "more conservative treatment" should have been used.

The Doyle report expressed amazment that hysterectomies had been performed on 86 per cent of the women with menstrual disorders without first undergo-

ing curettage. This comparatively simple procedure involves scraping the uterus cavity clean.

"One might speculate," Dr. Doyle noted, "as to how many of these hysterectomies would have been obviated had this diagnostic procedure been employed."

He also scored many doctors for deciding upon a hysterectomy for scientifically invalid reeasons. He reported:

"Pain was the only complaint of 185 patients and backache the single symptom of 86 others subjected to hysterectomy, in none of whom did a pathological lesion actually exist."

Duff and Hollingshead, in their study of a first-rate hospital, found that some patients—especially women—like to revert to a child's role and be "taken care of" by physicians. Some of these women, perhaps subconsciously, "shop around" for operations. If they shop long enough, they usually will find a surgeon willing to accommodate them.

One patient, known as "Mrs. Leadon," spent much of her time discussing the physical examinations she'd undergone. She'd collected quite a few "conversation pieces." In a single year she'd persuaded various doctors to give her a full gastrointestinal series, to perform two breast biopsies and administer other tests. She'd been admitted to the hospital by another physician who had agreed to perform a third biopsy.

When the surgical resident told Mrs. Leadon shortly after her admission that he didn't think the biopsy was necessary, she became furious and ordered him from her room.

Mrs. Leadon's own surgeon visited her daily, held her hand sympathetically and let her talk at length.

We can rest assured he was well paid for his solicitude.

Another woman, fearful of cancer but who didn't dare mention it, persuaded docors to hospitalize her several times. There, she underwent complicated tests to try to learn the source of her abdominal pains.

Each new visit to the hospital made her more fearful. She became convinced the doctors, too, were secretly suspicious of cancer. The more nervous she became, the more severe her pains.

Finally, an exploratory operation was performed.

Everything was found to be perfectly normal.

The operation—with its attendant pain and danger—cost the woman $5,000.

But one doesn't have to be a Mrs. Leadon or a hypochondriac to fall victim to an unnecessary operation. A good rule of thumb when faced by any surgery is to get more than one medical opinion—and make sure the two doctors aren't old friends.

CHAPTER TEN

TRAGIC MISTAKES IN THE OPERATING ROOM

Even when an operation is necessary, it often subjects the patient to unnecessary danger because of the ignorant or careless manner in which it is conducted.

In fact, poor operating techniques sometimes pose a larger threat to one being operated on than the physical condition which forced him to seek surgical relief in the first place.

It may come as a surprise to some readers to hear that one of the biggest dangers awaiting a patient in many operating rooms is dirt.

But, one might object, aren't hospitals noted for their cleanliness? Certainly the stereotype of an operating room is bedecked with freshly laundered, snow-white uniforms, gleaming silver instruments, and spotless surroundings.

Yes, but there are other things in many operating rooms which the untrained eye doesn't see. No matter how gleaming these operating rooms appear, they contain enough sources of possible infection to make them bacterially dirty.

One of the most common of these sources is the surgeon's mask, The *American Journal of Surgery* recently published the findings of two surgeons who had made a study of those impressive-looking masks which doctors and nurses wear in the operating room. The purpose of these masks, of course, is to protect the patient from any bacteria which the attendants might breathe upon them.

To pour bacteria upon an open wound made by a surgeon's knife is to beg for infection to set in. Yet that's exactly what these masks were doing.

The two surgeons found that some masks filtered out only 15 per cent of a particular type of bacteria. Much of the rest escaped, to rain down on the patient like invisible "fallout."

Another "open window" through which germs can pour into a freshly made incision is to be found in many surgeons' gloves.

When we see these gloves pulled over a surgeon's hands—usually with a snap—the gesture seems most efficient. But sometimes the gloves aren't. One study showed that small tears occur in them during as many as one out of three operations.

No matter how hard he scrubs, the surgeon can never get rid of all bacteria on his hands. When a small tear occurs in his glove, it provides a quick short cut for the bacteria which survived the scrubbing and which later emanated from the surgeon's skin to infect the patient.

There are apparent solutions to both these problems —if only doctors would put them into effect.

Some experts who have made studies of surgical masks believe that the most efficient type is a disposable one made of spun glass. Others, even more concerned about the surgeon's gloves as a possible source of contamination, have suggested that wider use be made of "throw-away" sterile gloves, to be disposed of at the end of each operation. Many hospitals, to save a few dollars, resterilize the gloves for reuse.

Indications are that many surgeons are not well aware of the threat these two obvious sources of possible contamination can pose to patients.

The journal, *Modern Hospital,* recently published a letter which was distressing in the ignorance on the part of some surgeons which it displayed.

"We have a disagreement in our operating room on the need to remove gowns and gloves in the room where the case is done," the letter said. "The surgeons believe that keeping on gown and gloves saves time between cases, since they do not have to do a complete scrub. Nurses believe that this practice is poor technique. What is your opinion?"

The *Modern Hospital* columnist, Frances Ginsburg, a registered nurse, then delivered a little lecture which all surgeons should attend. She wrote:

"Gowns and gloves should be removed in the room in which the surgery is done and discarded for treatment and disposal along with other supplies. Wearing gowns and gloves from room to room results in spreading bacteria from the gown and contaminating whatever is touched by the gloves."

The patient lucky enough to have bacterially "clean" doctors and attendants working in sterile surroundings

has still another hurdle to overcome if his operation is to be a complete success. And that is, he must survive the anesthesia.

Anesthesia has become such a "routine" part of modern surgery that, not only is its use taken for granted, but its dangers are hardly discussed. Yet a considerable number of persons die as a result of anesthesia each year. And indications are that this death figure might be considerably reduced if anesthesia were given the attention it deserves in modern medicine.

Dr. Robert D. Dripps and his fellow workers at the University of Pennsylvania made an extensive study of hospital deaths by anesthesia. Their findings, published in the *Journal of the American Medical Association,* indicated that approximately one out of every 415 operations resulted in death which could have been caused by anesthesia.

Of the 33,224 surgical cases studied between 1947 and 1957, there were 80 deaths which were a "definite" result of anesthesia or a "possible" one.

Let's examine the full implication of those figures. Each year, some 13,900,000 Americans undergo anesthesia. If the findings of this University of Pennsylvania team of anesthetists should hold true for all cases, it would mean that approximately 33,493 deaths might be caused by anesthesia each year.

Yet among the least known—or ignored—dangers of modern medicine are the hazards of anesthesia. We are forced to this conclusion when we consider the large number of poorly trained hospital personnel who are often given the life-or-death responsibility of administering anesthesia.

Each time a patient is anesthetized, definite dangers

are posed to his brain, heart, lungs—and life itself. General anesthesia, in addition to bringing about unconsciousness, depresses vital functions of the body. The respiratory, circulatory and metabolic systems are slowed far below their normal rate of speed.

If too much anesthesia is given, the heart may stop. The patient may become suddenly ill—and choke to death on his own vomit. Or too little oxygen might get to his brain, causing brain damage.

An anesthesiologist is a trained physician who specializes in the administration of anesthesia and its peculiar effects on various functions of the body. For example, he's keenly attuned to the fact that the slightest rise in temperature in an anesthetized patient is a possible sign of extreme hazard. He's trained to be on the lookout for other early signs of danger and knows just what prompt steps to take to avoid an operating-table tragedy.

Is this skilled specialist on hand for all operations? He's not on hand for even most of them.

In fact, for 57 per cent of the operations performed in this country, the anesthetic isn't even administered by a doctor—much less an anesthesiologist.

For most operations, the task of giving anesthesia falls to a nurse.

In theory, of course, the surgeon in charge of the operation supervises his nurse-anesthetist helper and sees that she doesn't make a mistake. This is a risky procedure.

Many times the surgeon is kept too busy with some unexpected development in his surgical task to keep adequate tabs on the anesthetist's job.

If, as in the great majority of cases, the unexpected fails to materialize, there's nothing to be lost by this

system. But if things go do wrong, the thing that can be lost is the patient's life.

What can go wrong besides giving the patient too much anesthesia? All sorts of things which, chances are, most patients blissfully going to sleep on the operating table wouldn't even dream of.

For example, the inhalation of general anesthesia, a method still employed at times in some hospitals, has its peculiar danger. An explosion of the inflammable and explosive anesthetic agents sometimes has taken place right inside the patient's lungs.

Oxygen cylinders in some cases have become empty without being noticed in time. This can cause asphyxia, an excess of carbon dioxyde in the bloodstream, leading to possible brain damage or death.

The anesthetic gases and oxygen used in the operating room are under considerable pressure. Sometimes inexperienced personnel have knocked off the valve of a full cylinder. When this happens, the heavy metal cylinder is spun around the operating room as though it's jet-propelled.

The *Encyclopaedia Britannica* lists other dangers and precautions with which one administering anesthesia should be thoroughly familiar:

"Certain anesthetic agents, such as trichloroethylene, can cause cardiac arrest when administered in full anesthetic dose. In the case of local anesthesia the danger is that the quantity of the local anesthetic introduced into the blood stream may be sufficient to cause convulsions or even cardiac arrest. Convulsions can be controlled by intravenous administration of a barbiturate such as thiopental sodium. Oxygen can be administered, the rationale for this being that death occurring during convulsion is due essentially to inability to

breathe. Blood pressure may fall to a dangerously low level.

"These catastrophes occur when anesthesia is administered by untrained and unskilful persons; they seldom take place when the anesthesiologist is experienced and trained." (Italics author's)

If these catastrophes can occur when the anesthesiologist is undertrained, what disaster might befall the patient if he falls into the hands of an anesthetist-nurse with little experience?

The patient who survives the threat of infection and the danger of anesthesia has then only to hope that the surgeon of his choice—if, indeed, he is a surgeon—is neither a butcher nor a clown. As we've seen, many operations are still performed by G.P.'s. And neither category, physicians or surgeons, are completely free of these two blights. Witness:

Successful legal cases have been brought to court after doctors have—

—Amputated the wrong limb.

—Performed a hysterectomy instead of an appendectomy.

—Taken out any number of healthy organs instead of the offending, diseased one.

—Sewn up assorted instruments and other foreign objects in patients. One of the objects most often lost in a patient is a surgical sponge or two.

Sometimes the butchery carried out in the operating room is made necessary by sloppy medical practice which preceded it. A notable example of this is given in *Life and Limb,** a biography of attorney Melvin M. Belli.

Belli has tried more medical malpractice cases than

**Life and Limb*, Robert Wallace, 1955, Doubleday

any lawyer in the United States. He's learned that to win these tricky cases, which many personal-injury attorneys won't touch, a sense of the dramatic is often useful.

He once obtained a $115,000 judgment against a plastic surgeon who had performed an inept job of giving a permanent lift to a woman's breasts. Belli succeeded in obtaining the court's permission for the woman to show the jurors her breasts.

They were still flat.

But the case more germane to our immediate discussion concerns a young man who one day noticed what appeared to be a wart on his male organ. He claimed he consulted two doctors who gave him wart medicine and told him not to worry. Following their instructions, he returned in two months' time.

Again the doctors assured him he had nothing to worry about. But after several months, it was discovered that he had cancer. Most of his organ had to be surgically removed.

Belli rightfully contended that the doctors should have performed a biopsy. This consists of taking a small number of suspected tissue and examining them under the microscope for traces of malignancy.

Belli then referred to such well-known sexology works as those by Dr. Kinsey, pointed out that the man was only 27 years old and might reasonably have expected many years of service from that which had been taken from him. "Ah, ladies and gentlemen of the jury," he cried, "what value shall we place upon this? *Can* we place an arbitrary value upon a loss so devastating? Can we say that one dollar per occasion, or five dollars, or . . .?"

The jury awarded the mistreated patient $100,000.

Some patients have survived serious operations—only to die of lack of attention in the recovery room. Dr. C. Brudzynski writes in *Annals of Western Medicine and Surgery*:

"One of the most common causes of anesthetic deaths is nursing the unconscious patient in a faulty position. The problem is one of simple mechanics. With the patient lying on his back, if the jaw is left unsupported, the tongue will fall back and occlude the airway. This is an elementary fact which generations of instructors in anesthesia have drilled into their students over and over again. When the operation ends, this danger remains unchanged.

"And yet, for some unknown reason, the anesthetist may turn over the unconscious patient to an attendant who puts the patient flat on his back in bed and leaves him unsupervised, often for considerable periods."

It seems obvious from the cases cited that, as long as a surgery patient remains unconscious, he unhappily meets that old description of "having one foot in the grave."

"The operation was successful
but the patient died."
—Old Joke *(Circa 1883)*

CHAPTER ELEVEN

ABORTION: THE MEDICAL UNDERGROUND

Abortion is by far the most controversial surgical operation performed. All states permit such an operation when the life of the mother is at stake. But, since most women seeking abortion do not fall into this category, comparatively few of these operations are legal.

Studies indicate that as many as 1,200,000 illegal abortions are performed in the United States each year. A number of these are performed by skilled doctors under antiseptic conditions. Under these ideal conditions, an abortion is considered a minor operation. Complications very seldom develop, and the general public hardly ever hears about it.

Because of the social and legal stigma against them, however, most of these operations are performed by

incompetent quacks. They represent the dregs of the medical profession or are clumsy butchers who have had no medical training of any sort.

Authorities estimate thas as many as 10,000 women die in the United States at the hands of undercover abortionists each year.

In 45 states, doctors can legally perform an abortion only if the pregnancy endangers the mother's life. Four other states, in addition to allowing abortions under these circumstances, permit such operations if they will help preserve the mother's health.

These limitations make legal abortion impossible for the great majority of women who wish them. Studies show that mose illegal abortions involve married women who don't want more children.

In 1962, when Mrs. Sherri Finkbine sought an abortion to avoid giving birth to a thalidomide-deformed child, she found that no American state permitted abortions to prevent the birth of physically or mentally defective children.

Since that time, one state—Colorado—has passed a liberal abortion law which legalizes abortions in cases such as that of Mrs. Finkbine. This new law, which was signed by Governor John Love on April 25, 1967, permits abortions under these circumstances: 1) When the pregnancy is the result of forcible or statutory rape or incest. 2) When it is likely that the child would have a grave physical or mental defect. 3) When the birth would endanger the mother's life or health or would cause her mental harm.

When Colorado enacted the most permissive abortion law in the nation's history, a cry went up that the state would gain a reputation as an "abortion mill." The new law has no residence requirement; and the fear

was that Colorado would become an "obstetrical Nevada," thus attracting out-of-state, abortion-seeking women the way Reno and Las Vegas draw women bent on divorce.

This prediction might eventually come true, as more women learn of the law—and start visiting psychiatrists. For one of the law's requirements for a woman who applies for an abortion on grounds that it will save her mental health is that she produce a psychiatrist's written testimony to this effect.

First indications are, however, that Colorado need not fear an abortion traffic jam. The Colorado Health Department reported in January, 1968, that in the first eight months under the new law a total of 120 legal abortions had been reported in the state—only 15 a month. Nine of these 120 women were victims of rape.

In his book, *Abortion,** writer-journalist Lawrence Lader tells of a rarity found in the annals of American medicine—a skilled and successful doctor who openly made a specialty of abortion.

This curious case concerns Dr. G. Loutrell Timanus, of Baltimore, who openly crusaded against abortion laws—and who, in the end, learned that many physicians' public views on abortion aren't the same as the ones they're willing to express in private.

"Timanus was no ordinary practitioner," Lader writes. "In Baltimore, and virtually along the whole East Coast, he had built an impressive reputation over twenty-five years as a skilled abortionist. Professionals have called his work extremely competent. At Johns Hopkins Medical School, classes in dilation and curettage, based on some of his techniques, were unofficially known as 'Timanus Day.' "

**Abortion,* 1966, Bobbs-Merrill.

Dilation and curettage is an operation legitimately employed for several reasons. Known as a "D-and-C," it is used to clear out infection or possible sources of infection from the uterus after a miscarriage. It can also be a diagnostic aid or a treatment for various conditions, including polyps.

The operation consists of dilating the cervix, or mouth of the womb, and using a curette, a special scraping tool, to scrape the uterus free of tissue. Basically, an abortion consists in performing a "D-and-C" on a woman when she is pregnant. The fetus is thus scraped from the uterus along with other "excess tissue."

In unskillful hands, the curette can be a murderous weapon. But, when performed properly, the operation is not considered a very risky one. A major disadvantage of most illegal abortions—even when performed by an otherwise skillful abortionist—is that they are performed without anesthesia. This is a painful procedure. But, because of the criminal nature of his act, the abortionist wants the woman to walk out of his office immediately.

Not Dr. Timanus. According to Lader, "Timanus treated his cases with intricate care. The operation was divided into two parts, usually on separate days. After surgery his patients rested in bed in his nurse's home at least six hours. He checked their recovery by phone the next few days."

Timanus' patients, Lader says, were accepted only with a referring letter from one of a list of 353 prominent doctors. What's more, at least 10 per cent of his cases were women doctors, wives or sweethearts of doctors, nurses or others related to the profession. He practiced in the building in which he was born, his

nameplate on the door, and his name and number in the telephone directory. He "always proclaimed his profession openly at the highly fashionable clubs on Maryland's eastern shore and at Miami Beach to which he and his wife belong."

In 5,210 cases recorded by Dr. Timanus, Lader reports, there were only two deaths. And Timanus was quoted as frankly telling a medical conferrence, "Whether these two deaths were attributable to my negligence or whether they were incidental, I would find it hard to say."

After Timanus had practiced openly for a quarter of a century, he suddenly was arrested and tried. Convicted on November 7, 1951, he was fined $5,000, served four and a half months in jail and never returned to practice.

Lader says Timanus' files contained letters from many outstanding doctors, not only requesting a "D-and-C" on their pregnant patients—a euphemism for abortion. But they also thanked him and praised his work.

Yet Timanus refused to subpoena a single physician to testify for him. Instead, he sent all 353 doctors on his list a letter saying:

"I do feel that having done this work legitimately, referred by doctors to me, that all doctors should take this case that is now pending against me as casting a reflection on their good judgment and their ability to decide which of their patients should have what treatment."

The result of Timanus' plea? Not a single doctor even answered his letter—much less appeared on his behalf in court.

In *The Healers,* the author signing himself "Anony-

mous, M.D." tells how most "extra-legal" abortions are performed. The woman who has a family G.P., he says, can sometimes obtain an abortion "only slightly illegal and (which) includes a bit of well-earned bed rest as a reward."

He says the G.P. inserts some kind of probe—it may be merely a Q-tip swab—into the uterus and agitates it. The object is to set up a reaction which will result in the patient going into labor and aborting the fetus.

This seldom happens, however. More often, "by fiddling about as he has, the G.P. causes infection. He may produce a certain amount of bleeding. In either event he has created the opportunity to pass his patient along to a gynecologist with a request for a D-and-C to clear out the infection or the presumed miscarriage.

"Once the gynecologist takes over—whether he suspects the truth or not and, if he does, he overlooks it for a fee—he can sign the patient into the cleanest, prettiest, best hospital in town, curette her at both their leisures and reward her with a few days of rest and sleep in bed.

"In effect, the gynecologist has performed an abortion, but all quite legally, since it was the G.P. who induced it. No one makes a practice of wondering aloud why the G.P. found an infection or bleeding."

So far, we've discussed safer types of abortion. None are easy to obtain, certainly for those unable to pay the high fees usually involved.

Illegal, often unsanitary abortions cost as much as $2,000, and Colorado physicians will charge about $500 for legal, sanitary ones.

Not every woman who can afford a regular, family G.P. will find him as cooperative as the one described by "Anonymous," and not every cooperative G.P. will

find such an unquestioning gynecologist. Few women, indeed, know eccentrics like Dr. Timanus, who practice abortion more or less openly. And not every woman lives in Colorado or can afford to take a trip there, any more than she can to such thriving abortion centers as San Juan, Puerto Rico, Tijuana, Mexico, and Tokyo, Japan.

What do most women do when they find themselves pregnant and are determined not to have the child? Two possibilities are left open to them. And whichever step they take may be their last.

The luckier of these unfortunate groups will find an unlicensed doctor or a former medical student who, at least, has been trained in how to use the curette. He may be an alcoholic who needs a half a glass of whiskey to steady his hands. Or he may be a sex pervert, who offers a cut-rate fee if the patient submits to his sexual peculiarities. Either one may inadvertently kill her. But, statistically, she has a slightly better chance of surviving the operation than if the abortionist has had no formal training at all.

But most abortionists apparently feel that they don't need such training. Those arrested for performing abortions include bartenders, prize-fighters, construction workers, hairdressers and prostitutes. Apparently every occupation from truck driver to lumberjack produces its share of those who have no conception of anatomy or hygiene but who, for a price, will attempt to perform on a kitchen table an operation which—if performed at all—should be done by skilled hands only in an operating room.

Roughly two-thirds of those arrested for criminal abortion in New York City have no medical training whatsoever. But usually these unskilled laborers have

no trouble finding a job as "doctor" for a thriving abortion ring.

Such a ring follows the tactics and code of the underworld. "Feeders" steer paying customers to it by means of telephone calls to unlisted numbers. The numbers, as well as addresses, change frequently. That's more than you can say for the sheets on the "operating table"—if there are any to begin with.

The woman doing business with such a gang is usually met in an alleyway or the lobby of a sleazy hotel. Sometimes she's blindfolded. Even if she knows where she is when the operation is performed, she doesn't know who's performing it. The abortionist often works behind a screen. This perhaps is a good thing, for the woman then can't see his hands.

Despite the obvious dangers involved in these operations, enough women seek them to make them hightly profitable—until the ring is broken up. Some rings have collected as much as $200,000 a year. The dissolution of such rings often follow the death of a patient on the operating table.

In even greater danger, usually, is the woman who decides to perform a do-it-yourself abortion. This is frequently tried with a catheter, a rubber tube bought at a drugstore. The catheter is designed to draw off urine in some cases of illness. Even then, it should be used by a doctor only. But many women try to insert this tube in the cervix in an effort to induce abortion. Their attempts often end in painful death.

Other women have died trying to induce abortion by inserting other foreign objects or substances into their uteruses. These have ranged from pieces of wire to soap solutions. The former can cause fatal hemorrhaging. Soap, when it enters the bloodstream through the uterus' bloodvessels, also brings on death.

A recent survey of some 40,000 American doctors showed that 86.9 per cent of them favor more liberal abortion laws.

The editors of *Modern Medicine,* a magazine for physicians, said they believed the 4,089 returns received from their questionnaire represented a good cross-section of American doctors, both geographically and by specialty.

Attempts to change abortion laws are underway in about half the states. But, with few exceptions, they have run into strong opposition. And organized medicine—regardless of what doctors say about present laws in private—has shown little inclination to spearhead any reform movement.

". . . from the time when one is sick to death,
One is alone, and he dies more alone."

—Robert Frost *(Home Burial)*

CHAPTER TWELVE

ANY HOPE FOR THE MENTALLY ILL?

Physical ills comprise dangers and hardships aplenty for the patients requiring skillful medical treatment and care. But patients who are usually in even bigger trouble are the ones who find themselves in need of mental therapy.

Ancient man showed a surprising knowledge about psychiatric illnesses. References to mental disorders in early Greek, Roman, Egyptian and Indian writings displayed keen insight. But the philosophers and theologians—as well as the physicians—who wrote about these problems believed they were caused by the displeasure of the gods. They thought some symptoms were caused by demons who had entered and taken posssesion of the patient's body.

As a result, little was done in the way of trying to

cure mental illness. The patient was sometimes banished, just to make things a little quieter for those left behind. Or, at times, mentally disturbed persons were punished. The theory here was to make things so uncomfortable for the demons inside the victim's body that they would flee to seek residence elsewhere.

The *Encyclopaedia Britannica* mentions one of the earliest attempts to cure mental cases by methods not too far removed from some modern ones. "As early as 860 B.C.," it says, "some Greek priests supplemented their incantations and exorcisms for the mentally disturbed with recommendations for kindness and physical and recreational activities such as walking, riding and listening to soothing music."

But mankind then took a step backward. By medieval times, medical thought was dominated by witchcraft and demonology.

Broad scientific interest in the working of the mind dates from the arrival of Franz Anton Mesmer in Paris, in the eighteenth century. He happened to be convinced that his hands contained a magnetic healing power which could cure, among other things, hysteria. A lot of people agreed with Mesmer; for he had striking success curing a number of hysterical cases as if by magic.

Mesmer's work was studied by a committee appointed by the Academy of Sciences. One of its members was Benjamin Franklin. The committee was impressed with Mesmer's work; but it warned of possible dangers, particularly if Mesmer's system of putting the patient into a trancelike state was practiced by lesser imitators.

From Mesmer, of course, we get the word "mesmer-

ize"—a form of hypnotism. And hypnotism is still used in treating some forms of mental illnesses.

The theoretical structure upon which much of modern psychiatry rests was founded by Sigmund Freud. Though he died in 1939 and much of his teaching has long since been embodied in scientific thought, numerous areas of the world today still treat mental illness much as the ancients did: They banish the victims. That particular kind of "treatment" is not unknown right here in the United States.

It's different with the well-to-do-person who suffers a neurosis. Usually he has no great problem. He visits a psychiatrist now and then to talk about his troubles. For this, the psychiatrist charges him anywhere from $25 to $50 an hour.

The frequency of his visits depends on how big his troubles and, to some extent, his bank account are. While some patients undergoing therapy can get by with a visit every other week, most of those who can afford it have at least one psychoanalytic session a week. Many of them have two or three.

It quickly becomes apparent, then, that some patients are paying more annually for psychiatrist fees than a lot of men can hope to make in a year.

How long this financial burden lasts depends on the patient's progress. Some mild neuroses are successfully treated in a matter of weeks or months. The "average" treatment, if such a statistical absurdity could be located in the record books, would probably be shown to last a year or two. But many of those who can afford such a medical luxury go to psychiatrists for years.

This situation is encouraged by a number of unscrupulous psychiatrists, particularly of the Park Avenue

variety. They take unethical advantage of a peculiarity of neurotics, known as transference.

Visiting a psychiatrist is a much more personal thing than visiting a general practitioner. Even for those patients overcome by modesty, there is only so much of the human body the G.P. can examine.

But the secrets of the human mind are almost limitless. And it's this "off limits" region, of course, which the psychiatrist explores in depth.

As a result of this probing into his secret life, the neurotic eventually develops toward the psychiatrist an emotional relationship—both of an affectionate and a hostile nature. Just which way the relationship goes depends to a great extent upon the patient's Oedipus complex—the relationship he had with his parents.

In any case, by transference he'll drape these old emotions around his psychiatrist like an unwanted cloak.

Now, this transference of the patient's emotions can be an invaluable diagnostic tool to the psychiatrist. He can examine this "cloak" he's been given and search it for clues to the patient's inner conflicts. These clues eventually may enable him to lead the patient to do away with his internal resistances and repressions.

The ethical psychiatrist is honor-bound to give the patient back his "cloak" as soon as he's made this use of it. He does this by helping the subject channel his emotions into more suitable areas of his life.

For the unethical psychiatrist, however, the temptation to play "God" is sometimes too great. Through financial greed, some psychiatrists keep patients dangling on an emotional string for years.

Their reason for doing this may not always be money. It may be just the love of misdirected power which

they wield over the patient. In other words, psychiatrists can be sick men themselves.

The vast majority of people who need psychiatric help aren't even as fortunate as the ones who see—and pay—their analyst for years. These are the ones who see no analyst at all.

A brief look at statistics shows how far the demand for such help exceeds the supply. The National Committee Against Mental Illness Inc. estimates that the nation needs at least 10,000 more psychiatrists. But examining other figures will probably convince us that even this estimate is far too low.

There are 18,750 psychiatrists currently in this country, most of them in private practice in such major population centers as New York and Los Angeles (Hollywood). By contrast, the bed population in the nation's 302 public mental hospitals is 426,000.

This means that if the hospitalized, mentally disturbed patients were suddenly to be treated on an equal basis by the total psychiatric manpower in this country, each doctor's case load would be increased by more than 20 new patients.

This figure alone doesn't convey the full story. Remember, we're not speaking of 20 new patients who need a quick physical or shot of penicillin. At the extreme minimum, turning these patients upon the nation's psychiatrists would increase the doctors' workweek by more than 20 hours.

In addition to this unsatisfied demand for psychiatric attention, there's abundant evidence that only a fraction of people walking the streets in need of such services ever receive it.

One study shows that, at one time or another, one of

two New Yorkers has been in need of psychiatric help. Needless to say, few of them got it.

Shelving the overwhelming problem of the mental health of the nation as a whole, let's look at the ones who need attention most—the 426,000 residents of public mental hospitals.

What is life like for them? And how do some of them get there?

Four years ago a man named Robert Rohmer was riding his bicycle through Stoughton, Massachusetts. His destination was Boston, about 20 miles away. It was late at night.

True, most people make such a trip by automobile. For that matter, most of them make it in the daytime. But Rohner was minding his own business and doing nothing wrong.

A policeman stopped the cyclist. Who was he? Where was he from? What was he doing on a bicycle in the middle of the night?

Didn't he think this was acting a little peculiar?

Rohner protested the way he was being questioned. For his own immediate good, he protested too vigorously. He was arrested and charged with vagrancy.

Rohner was incensed. Before the incident was over, he was written up in the police blotter as being "belligerent in violent protest at his arrest."

By the time he showed up in Stoughton District Court the next day, Rohner was in a straitjacket. Policemen had fitted him into it because he was still angry, still demanding to be released.

The judge ordered Rohner to be taken to Bridgewater State Hospital for the Criminally Insane for 30 days of observation. The "observation period" stretched out into nightmarish years.

Finally, he was released. The only thing they ever found wrong with Rohner was that he'd ridden a bicycle at night in Stoughton, Massachusetts. But, considering how much attention many inmates at Bridgewater got, it's a wonder they ever reached this diagnosis.

Take another inmate of Bridgewater, Dominic Rosati. He had no more success than Rohner in persuading authorities to set him free. But he finally made a successful kind of escape attempt. He was found dead in his cell, a victim of rat poison.

A legislative committee began an investigation. So did a young lawyer named Frederick Wiseman. In 1958, Wiseman had been teaching a group of law students who visited Bridgewater. He couldn't forget what he saw. He finally decided to show the world what he'd seen in a documentary film.

The movie, "The Titicut Follies," became a critical success and a political bombshell. A court order barred the film from being shown in the state of Massachusetts.

The documentary showed hospital inmates living lives no better than animals. In one unforgettable scene, a middle-aged man, pictured nude, is provoked by a guard into throwing a tantrum.

This patient—until his illness—had been a junior high-school math teacher.

Are conditions which were found at Bridgewater common to many "insane asylums"?

Indications are that they're at least not rare.

In 1956, the *Saturday Evening Post* ran a series of articles by John Bartlow Martin. After spending months in research, Martin chose Columbus State Hospital in Ohio as a typical example of the way Ameri-

cans treated the mentally ill who could not afford private care.

In one of the nation's wealthiest states, he found 2,700 patients served by 18 doctors—none of these a trained psychiatrist.

Only ten of these doctors, as untrained as they were, attempted to give some kind of daily psychiatric care to selected inmates.

Only about 400 inmates were receiving *any kind* of therapy.

The remainder of the patients were there on a state budget of $2.60 a day, with only one thing to wait for —death. Some had been there for as long as 60 years.

Conditions have improved greatly in a number of mental hospitals since that time. But, obviously, not all of them.

In 1961, Congress appointed a Joint Commission on Mental Illness and Health which confirmed that such findings as Martin's could be found on a nationwide scale. The lawmakers then passed the Mental Health Act of 1963.

As a result, some $60-million has been awarded for the construction and staffing of 128 mental health centers in 42 states, Puerto Rico and the District of Columbia. But construction is relatively easy. The problem still remains how to staff them adequately.

Only six years ago mental institutions such as State Hospital No. 2, in St. Joseph, Missouri, kept some of their more unmanageable inmates chained to the walls. But, though such practices still exist in some communities, a new emphasis today is on rehabilitation rather than hopeless incarceration.

What's the source of this ray of hope which has

stabbed into the darkness of mental hospitals? New drugs.

Tranquilizers and other psychiatric drugs can calm the maniac or stimulate the depressed. True, in most cases these drugs only control the symptoms, rather than curing the psychic disorder itself.

But while the patient is in a more "normal" state of mind, the psychiatrist has a chance to communicate with him and apply more lasting therapy.

Largely as a result of these drugs, mental patients are now discharged from hospitals with increasing regularity. As long as they stay on their pills, they can often lead more or less normal lives.

Consequently, the population of the nation's mental hospitals actually has fallen in the last year or so, on a per capita basis rather than taken an expected rise.

The National Committee Against Mental Illness says that, in the ten years following World War II, mental hospitals were increasing in population at the rate of 13,000 a year. In the next ten years, that figure dropped to 8,300 patients a year.

This decrease doesn't represent a decline in the incidence of mental illness. But as more patients are admitted each year, increasing numbers are discharged.

Many, of course, will be back. But the national mental-health picture remains so gloomy that concerned observers are thankful for any new ray of hope.

"I find the medicine worse than the malady."
—John Fletcher *(Love's Cure)*

CHAPTER THIRTEEN

JUST TRY TO FIND A DOCTOR

Doctors are second to no professional group in their mastery of absenteeism. Just as policemen frequently seem to be scarce in an emergency, so do those men in white who can sometimes spare us suffering or save our lives—if we can only find one.

In days of old, the familiar cry used to be: "Is there a doctor in the house?" That question has taken a radical departure, so that most of the time and during entire seasons—namely on weekends, Wednesdays and the entire months of July and August—the desperate query is more apt to be : "Is there a doctor?" Period.

The house call, of course, has become almost as obsolete as the horse and buggy which the doctor once drove. Now that he's acquired a Cadillac, the big trick these days is even to locate him. The modern man of

medicine, to a large extent, has succeeded in isolating himself from the public he supposedly serves.

His office hours are sometimes posted on the door. But, outside of those hours, there is hardly any clue as to his whereabouts. He keeps his movements secret by such devices as the unlisted telephone number and the impersonal, know-nothing telephone answering service.

In an emergency, all a patient can do is dial the number of the doctor's office. Chances are that he'll be informed by a bored-sounding switchboard girl that she has no idea where the doctor can be reached.

In extreme cases, this unavailability of doctors has resulted in death. Volunteer firemen in Suffolk County, Long Island, once tried heroically to save the life of a male heart-attack victim. Police, assisting in the rescue attempt, telephoned 19 doctors before finding one. By that time, the victim had died.

Frequently, when the public feels it can do nothing else about a frustrating situation, it tries to laugh at it. Jokes about doctors are, therefore, plentiful. An old one tells the story of the physician who frantically telephoned a plumber in the middle of the night to seek his services in stopping an over-flowing commode. "Well," yawned the plumber, "flush two aspirins down it and bring it by to see me in the morning."

The availability of doctors even during office hours is further restricted by the lengthy vacations many of them take. During such times, the doctor provides his patients with the name of another doctor who "covers" for him. Many times, this system works better in theory than in practice. After being given the new doctor's name, the patient's task is now to try to locate *him* and get him involved with the problems of a person of whom he hasn't even heard.

Even when a patient is fortunate enough to be able to time his illness to suit a doctor's convenience, he's not always sure he's really reached the busy medical man. By which we mean that many modern doctors, even when physically present, often present a formidable facade of supreme disinterest. The patient frequently feels more like a broken machine in a workshop than a human being whose aches and pains are understood.

A large part of the breakdown in communication between doctor and patient has been caused by some of the assemblyline techniques adopted by many doctors. Some have converted their offices into sickness "factories."

Hurrying in and out of a number of cubicles, making use of color codes and other automation-like devices, they are able to attend several patients simultaneously. A nurse is summoned by a certain colored light outside one of the cubicles. She bustles in and gives the waiting patient any number of tests, depending on the color of the light. The doctor pops back in, just long enough to scrawl a prescription and hand it to the patient along with a manila folder.

The folder is given to the receptionist by the patient as he leaves. Often she can tell just by glancing at the way paperclips are arranged on the folder how much to charge the patient. Some doctors show a James Bond-like fondness for secret codes.

The *Journal of the American Medical Association* has, from time to time, been forced to take note of the growing communication gap between doctors and patients.

"The words 'personal physician' are appealing and thoroughly descriptive in a time when physicians are

under attack—justly or unjustly—for failure to provide sufficient comprehensive and continuing responsibility for their patients," admitted a recent issue of the *Journal*. "We would welcome their re-entry into our vocabulary and ranks."

A trend continues, however, to make of modern medicine an impersonal trade—like that of the plumber or auto mechanic—rather than the personal art of healing. This trend may have cost some doctors a degree of personal satisfaction; but financially, at least, it is a rewarding one. The average median income for doctors has become four times that of the average family. Their median *net* income exceeds $35,000 a year. Many of those in the upper brackets have practices which bring in more than a quarter of a million dollars annually.

In the past, doctors had a readymade rationalization for charging wealthy patients exorbitant fees. They had to do this, they argued, to balance their accounts against the considerable amount of time they spent on charity work for no pay.

Today, of course, this no longer holds true. Doctors are now paid at various levels of government or by insurance companies for whatever time they spend with those who once would have been considered medically indigent. Yet they still charge the paying customers what the traffic will bear. There are still a few exceptions, of course. But it's a rare occasion, indeed, when you can find one of these exceptions among the new generation of doctors.

"Young doctors of today have no humility," complains Dr. Richard C. Miller, an "old-time" doctor who has been practicing medicine for more than 30 years. Writing in the journal *GP*, Dr. Miller says the young

doctor of today "is a laboratory fanatic with no inner feeling for humans. He finds it easy to criticize, is unshakable in his opinions and lives on an inflated ego, believing he is the master of medical knowledge and he has all the answers.

"Instead, he is a downright fool; but he won't believe it, because the dollar signs have beclouded his vision . . ."

The doctor's quest for the dollar has taken him in fields far removed from healing. In *The Doctors,* Gross tells of physicians who have invested in such diverse enterprises as orange groves, trampolines, air taxis, bowling alleys, motels and hamburger stands.

But it's hardly necessary for most doctors to stray so far from his profession to make a very large income. Gross cites what he terms the surgeons' "traditional Robin Hood system of economics: soak the rich, and extract what you can from the poor."

For example, a doctor admitted that at one hospital the fee for a prostatectomy ranges anywhere from $200 to $2,000.

If a surgeon is involved in a dramatic, life-saving procedure, such as a cardiac operation or neurological surgery, the wealthy patient can expect to be billed for as much as 10 percent of his annual income for a few hours of work.

Quick money can also be made by many doctors just by a fast round of hospital visits. Traditionally, many doctors charge as much—or more—for a hospital visit as they do for an office consultation.

One young minister on Long Island learned about this the hard way. He received a bill from a doctor who had delivered the minister's wife of their baby.

He'd mentioned to his wife how nice the doctor was to drop by occasionally and say hello to her.

"I looked at the bill and discovered that every time the doctor had stuck his head in the door and said hello to her, it had cost me five dollars," the clergyman sighed.

Such generous solicitude on the part of the doctor had cost the struggling young minister an additional $25.

Cases like this represent the few times when a doctor is too available. But, as we've seen, most of the time the doctor isn't available at all. Where is he during his frequent absences?

He may be hiding out at home. Chances are that it's a luxurious one. Real estate dealers in posh residential areas surrounding New York City confide that almost 50 per cent of the homes they sell for $50,000 or more are purchased by doctors.

Perhaps he's sailing on his yacht. Yacht club membership is comprised of doctors by as much as one-fourth.

Maybe he's playing a round of golf. It's estimated that in most country clubs doctors represent as much as 35 per cent of the total membership.

If he's vacationing, chances are it's in Europe. A survey has found that the average doctor's vacation consists of three weeks to a month in Europe.

Americans with their free enterprise system have traditionally respected material success. Doctors certainly have as much right to success as any other professional group. But in many instances there are indications that a large number of doctors abuse this right. And the doctor's growing leisure and conspic-

uous affluence is apt to be quite rankling to those who habitually find the doctor "unavailable" during an emergency.

Is there an answer to this apparent lack of recognition of his public responsibility on the part of the doctor?

One possible solution suggested from time to time is anathema to such doctors' groups as the A.M.A. To them in fact, the suggestion itself sounds like dirty words.

Those words are "socialized medicine."

"Medicine is the only business that shows one hundred per cent profit."

—Bernard Shaw *(Prefaces)*

CHAPTER FOURTEEN

DIRTY WORDS: SOCIALIZED MEDICINE

When Congress passed the Medicare bill in 1965, it answered a question which had been debated for 20 years. The question was: Is medical care a right or a privilege?

Congress' answer at last: A right.

Opponents of Medicare had sounded dire warnings that American medicine would crumple immediately, overburdened by millions of elderly folk demanding medical care. The bill assured complete medical treatment for 19 million citizens over the age of 65. The medical attention they were to receive would depend for the first time, not on their ability to pay for it, but upon their need alone.

Despite the ominous predictions, the onslaught against organized medicine never materialized. The in-

auguration of the Medicare program was remarkably orderly. The overall increase in hospitalization in the first few months of the program amounted to only 5 per cent.

Admittedly, this caused considerable inconvenience at some already overcrowded hospitals. But these problems are said to be temporary, and the long-term future of Medicare appears bright.

In a remarkable about-face, many doctors now publicly agree that Medicare was a good idea. Dr. Willard A. Wright, a former chairman of the American Medical Association's Council on Medical Services, emphasizes that he speaks for himself and not the organization when he speaks favorably of some aspects of Medicare. For example, he approves of Medicare's rule requiring participating hospitals to set up committees to review the quality of hospitalization of Medicare patients. He says doctors for many years had urged hospitals to form such committees. Of Medicare's passage, Dr. Wright says:

"Congress was obviously aware of the current desire of everyone to utilize the best of health services—a desire that we physicians have long encouraged. Now, the law provides the financial means for the group concerned—those over 65—to obtain for themselves as good health care as is available to anyone else in the community."

The effects of the Medicare legislation will eventually be more far-reaching than many persons were aware at the time the bill was passed. For tacked onto it was a "sleeper" amendment which received scant attention at the time.

This amendment—Title 19—promises to be the

most significant social legislation passed since Social Security was put into effect 33 years ago.

Title 19 eventually became widely known as Medicaid. Its object: To abolish charity medicine.

Medicaid is designed to give those who can't afford to pay for it the same medical attention as given anyone else. These patients are to be treated by the same physicians in the same hospitals and charged the same rates as those who pay for these services. But the bills would be paid by the state and Federal government. The Federal government would pay anywhere from 50 to 83 per cent of the cost.

To participate each state must pass enabling legislation. Those which haven't joined the program by 1970 would be cut off from Federal funds for various aid-to-indigent programs.

The program varies from state to state. Each state decides for itself how much money a family may earn and still be eligible for Medicaid benefits. This figure ranges from a high of $6,000 for a New York family of four to a low of $2,448 for a family in Oklahoma. The New York law says that the family making $6,000 a year must pay 1 per cent of it—$60—toward medical bills. The state and Federal governments pick up the tab for the remainder—up to a ceiling of $4,500.

The "architect" of both Medicare and Medicaid is Wilbur J. Cohen, now Secretary of Health, Education and Welfare. He was also a drafter of the original Social Security Act. Cohen believes Medicaid is off to a good start.

"I'm a pragmatist," he says. "I like things that work well. I prefer to start small, the rest will come. We cannot deliver the highest quality medical care to nearly 200 million people overnight. But in 10 years, we

might not even need Medicaid. In an affluent society such as ours, who knows, maybe we won't even have any medical indigents."

Skeptics might scoff at such optimism. But the initial success of Medicare and rosy future of Medicaid offer us an opportunity to examine another medical-assistance program whose very name strikes teror into the hearts of most American doctors: socialized medicine.

Such a system, termed the National Health Service, has been in effect in Britain for 19 years. How is it working?

Its critics forecast its imminent collapse. The Minister of Health scoffs at the predictions of gloom. But he admits the program might need some overhauling.

The main problem is one of money.

In 1965, for example, five out of six general practitioners handed in postdated resignations from the service to back up their financial demands.

The next year, junior hospital doctors joined in to protest poor pay, overwork and awful working conditions. Other doctors are drifting away, to the United States or to countries of the Commonwealth. And the British Medical Association recently warned:

"Unless vast new sums of money are made available ... the present concept of a hospital service must be abandoned. It is not difficult to find instances of wards which are closed for lack of staff; of waiting lists which are growing longer rather than shorter; of services which are curtailed because essential equipment has broken down or cannot be manned."

And—perhaps the unkindest cut of all to the National Health Service—in a nation where medical care is free to anybody who wants it, more than 1,000,000 persons prefer to pay for private health insurance.

All this sounds grim, indeed, for socialized-medicine advocates. And, at first glance, it might appear that Britain's system of "free" medicine for all is collapsing.

Supporters of the program say, on the contrary, that some of the system's gravest ills can be traced to the fact that it works almost too well.

Abuses of the program were clear from the outset. Not only did Britons line up by the thousands to receive free false teeth and eyeglasses. Some elderly women hit on the notion of demanding three pounds of surgical cotton from their doctors with which to stuff pillows.

The old women didn't get their cotton. But patients still line up to have doctors examine small boils and twisted ankles—minor complaints which surely would be ignored in safety if the patients had to pay for the doctor's services.

Such demands on his time have caused many doctors to feel that they're working on a treadmill. Since some GP's have as many as 3,500 persons to serve, they can spend only three or four minutes with each patient on some visits. In some instances, this haste has led to unprofessionalism.

One British doctor recalls that a girl visited him after previous visits to another physician. She complained of a pain in her breast. "How long have you had it?" he asked.

"A year," she replied.

"What did your doctor find when he examined you?"

"He never examined me," she said.

The doctor quickly determined that the girl had a tumor. It was removed and found to be benign.

Is all black, then, for Britain's socialized medicine?

On the positive side, hospital medical staffs are 60

per cent larger than when the Health Service began. Nursing staffs are 40 per cent larger.

Two-thirds more patients are treated in the same number of hospital beds than in 1948. Medical authorities say this is an indication of improved methods of treatment.

Since the British government became so deeply concerned with the health of its citizens, money has hardly seemed an object. Between 1950 and 1965, the nation's health budget almost tripled. As Minister of Health Kenneth Robinson told junior hospital doctors at a spirited meeting in 1966:

"Ten years ago, you would have had to go far to find a new hospital under construction in this country. Today, they are a commonplace. Does anyone seriously imagine that we should be witnessing anything like this rate of new building and reconstruction if these things depended, as they used to, on charity, on private benevolence and on the expenditure of ratepayers' money?"

The most amazing thing about Britain's socialized medicine is that, despite its many troubles and complaints, the overwhelming majority of patients—and the doctors themselves—still favor it.

"What would we do without it?" asks one British citizen, Mrs. Jack Hedley. Her actor-husband adds:

"In the United States, you live in deathly fear of a major illness. We don't have that fear here."

The Hedleys, like most Britons, have become used to the idea that the illness of one person is a burden to be shared by all.

"I'm just old enough to remember when people were too poor to go to a doctor," recalls Tony Vandenberg, a broadcaster.

Doctors, too, echo this sentiment. A British Medical Association spokesman says, "Most doctors have been brought up on the idea of medical care for everybody when they need it. The doctors don't want to go back on this policy. They're not against the Health Service. They're against the manner it's been done in the first 18 years."

As reasons for their support of the system—in principle, at least—doctors point to the fact that socialized medicine has spread comprehensive medical care into areas where it previously never existed. It also has enabled doctors to prescribe the most effective medicines—regardless of cost.

Many also argue that "the Service" has resulted in better public health, since Britons now tend to seek medical attention for conditions and diseases they previously might have neglected because of the cost of visiting a doctor. This, despite the inevitable abuses of the free-treatment program, adds up to an improvement in the overall public health picture.

Among the changes suggested for Britain's ailing medical system is a proposed small charge for a doctor's services. This, some argue, would make a patient think twice before seeking medical care and would tend to cut down on the number of chronic complainers and malingerers. But opponents of this measure counter by saying that such a fee would defeat the whole idea of socialized medicine. The good done by such a fee, they say, would be more than offset by the fact that such a fee, no matter how small, would be too much for the poorest patients to pay.

Many Labor members of Parliament think, however, that they may have acted hastily when they voted to remove a token fee of two shillings for prescriptions in

1965. And one G.P. agrees. "If all the patients had to pay a little fee," he says, "it would cut down on the work. They've all got televisions. They could afford to pay a half-a-crown to see the doctor."

However Britain works its way out of its public-health dilemma, it seems certain that socialized medicine is there to stay. To a vast majority of its citizens, for them to adopt a system such as found in the United States would be like turning back the clock.

CHAPTER FIFTEEN

NAILED TO THE BLUE CROSS, OR CARRIED OUT ON THE BLUE SHIELD?

Perhaps no consumer is caught in a more complex and exacting squeeze play than the medical consumer —the patient. Regardless of the quality of the treatment or service he receives, in almost all instances he pays dearly. This holds true for patients who have seen the fees for hospital clinic treatment roughly double in the last few years to the affluent who are billed directly by an assorted number of doctors, specialists, medical technicians and the hospital when he becomes seriously ill.

A recent dispatch in the *New York Times* summarized the skyrocketing costs of medical care in this manner:

"A patient in Massachusetts found to his dismay that this hospital clinic had raised its fee for visits from $6.50 three years ago to $12.

"In Washington, a workman who had been badly burned in an accident was sent home recently after 85 days in the hospital. The bill was just over $30,000, but the patient did not seem to mind.

"A schoolteacher in West Virginia went to a hospital emergency room with a pain in the right side of his chest. He emerged later with no clear diagnosis and a bill for $62.

"In rural Mississippi, a mother and 11 young children have grits for breakfast, pecans for lunch, rice, beans and greens for supper. One of the children has periodic blackout spells, but, until recently, had never seen a doctor in her life.

"While each of these cases illustrates the rapidly rising cost of health in America, each gives a different aspect of the complicated problem."

Let's see what happened in each of these cases.

The Massachusetts patient complained to the National Council of Senior Citizens about the steep and steady rise in the cost of routine health care.

The burn patient in Washington didn't complain to anyone. He'd survived burns that covered 70 per cent of his body. Workmen's compensation insurance picked up the tab for extensive and expensive treatment that would have been unavailable a decade ago—at any cost.

The West Virginia teacher thought he was given a lot of expensive tests which served only one purpose—to relieve him of money. He found a doctor who agreed with him. That, we suppose, makes it some kind of moral victory.

The Mississippi family illustrates a fact often overlooked by members of the cocktail circuit when they're discussing their rising medical bills. The cost of medical care doesn't have to be more than what they'd consider "reasonable" for it to be much too high for the poor. A few dollars or a few miles can put a medical center completely beyond their reach. As the *Times* noted, "Medical problems in these cases might be largely solved by some decent food."

The nation's health care problem is probably as complex as any it faces, being comprised of millions of individual needs by persons facing hundreds of difficulties. But some of the easiest factors to detect and which affect virtually everyone are rising costs, a decline in health manpower and an increasing demand for health care.

Wilbur J. Cohen, Secretary of Health, Education and Welfare, testified at a recent hearing of a Senate Government Operations Subcommittee that personal expenditures for health care have increased since 1961 from $24.7 billion annually to $41.5 bilion.

He said more than a third of this increase resulted from increases in medical care costs. Some 15 per cent of the increase stemmed from the fact that the nation's population had increased by about 16 million persons. The remainder of the increase—almost half—was accounted for by greater use of services.

Greater use of health services has been brought about by two trends. First, improved techniques allow some treatments to be made where no such treatments existed before. And, second, more people are seeking these and other treatments.

The economic aspects of health care are bleak, indeed, for the consumer. Experts say costs will inevitably rise for the next several years, at least. This probably comes as no surprise to most readers; since medical costs have been rising for years. But those in

the younger age brackets could not be expected to realize how sharply these costs have accelerated.

Dr. Victor R. Fuchs, of the National Bureau of Economic Research, estimates that the nation's medical care expenditures amounted to about $4 billion in 1929. By the mid-1940's this figure had grown to $10 billion. But then it soared and, in just two years, had climbed close to $50 billion. Responsible in a large measure for this were Medicare and Medicaid.

In 1967 a day's care in a general hospital averaged $58.06. Figures supplied by the American Hospital Association indicate that this represented a 15.4 per cent increase over the previous year.

Many health authorities predict that a day of hospital care will *average* $100 in the near future. Besides the higher price, there will be a major difference in hospital care. Chances are overwhelming that the car available in the future will be poorer.

The figure of $100 a day for the average hospital bill doesn't seem farfetched when we consider that some hospitals already charge this amount in some cases.

A Presidential report said as long ago as 1967 that the rising cost of health was a major cause for concern. Big cost increases in this field "cause severe hardships to individuals in need of medical care, *whether they pay the prices directly or indirectly through higher insurance premiums,*" the report said. (Author's italics.)

It then added a truism which should concern all of us: "Medical price increases made Government-financed medical care programs more expensive for the taxpayer."

One reason that a continued rise in hospital costs

appears inevitable is the spiraling cost of hospital labor. For decades hospital employes were "second-class citizens" in the labor market, being paid far less than unskilled workers in industry. But in recent years, hospital employees' unions have succeeded in narrowing the wage gap.

Ray E. Brown, professor of hospital administration at Harvard Medical School, points out that "in the last five years, hospitals have made great strides in raising wages. They are now within 20 per cent of general wage levels."

To say that it's the hospitals which have taken these great strides in raising wages without mentioning the unions' part in pushing them along this path would not be presenting the full picture. Of more immediate concern to us, however, is the fact that efforts will be underway to narrow that 20 per cent gap still further—whether the hospitals continue to take these giant strides unassisted, or whether the unions involved will find it necessary to prod them from time to time.

Wage hikes in industry are usually quickly followed by bigger price tags on consumer products. Hospital bills can be expected to reflect such pay raises to an even greater degree. The reason for this, according to Brown, is that 60 per cent of a hospital's expenses are those for labor—as opposed to 30 per cent for industry.

Another big difference between industry and hospital administration lies in the varying effect new technology has upon each. In industry, technological improvements often bring a break for the consumer. New techniques can result in more production per man-hour. The manufacturer can pass at least part of his cost-savings along to the consumer. But not so with hospitals.

New hospital technology may spell life or death for some patients. But almost invariably they call for new equipment and more high-paid technicians to man it. This all adds up to a bigger hospital bill for all patients.

A recent item carried by United Press International points up the trend toward more expensive hospital equipment. It said:

"Now that transplant surgery has revolutionized medicine, a Chicago hospital is drawing up plans to revolutionize the operating rooms where transplants take place.

"St. Luke's Presbyterian Hospital has budgeted $1 million to 'sack the traditional operating room and start from scratch.'

"The master plan calls for four operating suites providing a biologically clean envelope to reduce the risk of infection, one of the major hazards of transplant surgery. Airborne microbiological contamination will be minimized by a practically particle-free atmosphere. Within the operating room, 99.7 per cent particle-free air will enter through large grills in the ceiling.

"Air will wash down over the operating team and the patient, removing infectious organisms. The 'dirty' air will exit near floor level.

"Plans call for about three to five complete air changes a minute. The present conventional operating room air is changed about six to twelve times an hour.

"Doctors and nurses will wear masks and transport their exhaled, and therefore contaminated, breath to packs placed over their backs.

"Gone will be the baggy greens worn now by surgeons. The new style will be tight-fitting, to reduce bad

air's lodging in the material. Nurses will wear tight, one-piece 'jump suits.'"

No one can deny that this is progress at its best. But, as the item suggests, it costs a great deal of money. And those who usually pay for a major share of such progress are the patients.

Also of increasing cost to the medical consumer is health insurance. Doctors share part of the blame for the inflationary rise in health insurance premiums.

In the past, insurance companies have increased their benefits to narrow the distance between what a treatment costs and what the insurance policy gives the patient to help pay for it. Almost immediately, many doctors have increased the fee they charge for such services.

More than one doctor candidly admits that he has two rates for services rendered—one for patients without insurance and a higher price for one who's covered. The insured patient thus pays for this artful dodge both ways—in increased insurance premiums and in higher fees for the doctor.

Insurance companies have also drawn the ire of some policy holders by employing some fancy maneuvering of their own. The following letter is a case in point:

"In January," a distressed mother wrote New York's *Daily News,* "my two-year-old son fell in a playground and injured his arm. A few days later we took him to the hospital for X-rays. . . . I sent a claim to Blue Cross for partial payment, but a few weeks later I got a letter saying I wasn't entitled to anything."

A reporter checked on the mother's case and learned that she was correct. She wasn't entitled to anything. Why? A clause in her policy specified that to be paid

for "emergency treatment" a patient must receive treatment within 24 hours of the accident. This policy holder—like thousands of others—got nothing in time of medical need despite years of paying high insurance premiums.

We can only speculate that things would have been no different had the lad suffered the injury in a plane crash and spent 24 hours atop an isolated mountain while rescuers attempted to reach him and the other passengers.

Sometimes the small print in insurance policies issues an open invitation for patients to court disaster. Many policies offering surgical coverage specify that the insurance company will pick up the bill for anesthetization only if the anesthesia is administered by hospital personnel. This is another way of saying that the insurance company won't pay the high fee of a trained specialist, an anesthesiologist. But it will be willing to pay a lesser amount charged for the services of an anesthetist-nurse. We've already noted that the difference in services rendered by these two can be the difference between life and death.

Another technicality required by many insurance companies results in higher overall medical costs—which, in turn, means still higher insurance premiums. That's the stipulation that, to be reimbursed for certain treatments and services, the patient must undergo them while he's hospitalized. This results, of course, in a number of patients seeking admission to hospitals just so they can collect insurance for treatments and diagnosis which could be made in the doctor's office.

This situation obviously contributes to hospital overcrowding. The overcrowding leads to new buildings.

And the new buildings eventually result in ever larger hospital bills.

Government-sponsored health programs, such as Medicare and Medicaid, have been criticized for making payments on a cost-plus basis. Some experts contend that this encourages inefficiency and rising costs.

The department of Health, Education and Welfare is sponsoring studies and experiments to try to find more efficient reimbursement plans. But no one expects a solution any time soon—if ever.

Meanwhile, of course, the taxpayer is paying for the rising health costs—as well as the studies and experiments supposedly designed to help reduce them.

"But when ill indeed, E'en dismissing
the doctor don't always succeed."
—George Colman, the Younger
(Lodgings for Single Gentlemen)

CHAPTER SIXTEEN

WHERE DO WE GO FROM HERE?

The long-range future of medicine and medical care seems extremely bright. It's the immediate future of these fields, vital to all of us, which appears in extreme doubt.

Many who are reading this will live to see medical "miracles" take place. Heart transplants, once regarded as impossible and still in a stage of initial development, give every promise of becoming routine before many years have passed.

A brief historical look at the amazing art of healing should convince us that even more astonishing medical achievements await human discovery and development in the relatively near future.

In an age in which human hearts have already been transplanted with some success, it's easy to forget that

man didn't discover that blood circulated in his body until William Harvey published *De Motu Cordis* in 1628. Until then, it was generally believed that blood ebbed and flowed in the body something like the ocean's tide. And, even with Harvey's discovery, no one was sure what was the purpose of the whole system.

It was hardly more than 200 years ago that James Lind discovered that lemon juice cured scurvy. Now, such scourges seem terribly old-fashioned. Greater knowledge simply side-steps many diseases, and wonder drugs stop the most common ones we encounter in their tracks.

A little more than a century ago, Louis Pasteur developed the first vaccine. In the comparatively few years since that time, vaccines have made a whole spectrum of diseases preventable. Whole generations remain blissfully ignorant of epidemics.

General anesthesia, which makes virtually all major operations possible, wasn't demonstrated successfully until 1846. Less than 125 years later, such delicate operations as open heart surgery are commonplace.

"Spare part" banks carrying an inventory of human organs, ready for quick transplants?

Already such a suggestion, which not long ago would have been considered a science-fiction writer's wild imaginings, has been taken under study by a number of learned organizations. And why not? Kidney transplants hardly make headlines any more. Even as this is being written, doctors are studying means of transplanting human lungs.

What about brain transplants? Such an operation is still enough to stagger the imagination of even jaded moderns. Consider the legal and psychological effects.

Would property acquired by the "donor" and "recipient" belong to the still-living brain—or to the body of the man whose remaining identity has been destroyed by death?

Where would this leave the relatives involved? Some would see a functioning body with which they had become intimately familiar over the years—but which is now controlled by a brain which tells the body that *these* are not *his* loved ones!

Such possibilities probably strike many of us as ludicrous now, of course. But in the vast span of history, the story of modern medicine has occupied but a brief moment. Considering its achievements in this short time, one can easily be persuaded that, medically speaking, nothing is impossible—as long as there's life.

And how long might that be for the average person? Strong indications point to the hope that man is on the threshold of discovering cures for such persistent killers as cancer. How soon until means are discovered to allow man to live 150 to 200 years—or longer?

Complicated pieces of apparatus already take over the function of the heart, lungs and kidneys during certain operations. What if these devices can some day be miniaturized? Is medicine marching toward an era which will see the production of artificial organs? The prosthesis industry may not always be confined to turning out such items as artificial teeth, eyes and limbs!

Imagine magazine ads praising the virtues of one kind of artificial heart over that of another manufacturer's!

Absurd? A few decades ago, the battery-powered "tin ear" was a fancy novelty used only by those hard-of-hearing with the money to afford them and the strength to carry them. They also didn't work very

well. If the person *really* wanted to hear, he'd resort to an "ear trumpet"—a small megaphone-in-reverse which he placed into his ear. Today, of course, there are numerous types of electronic hearing aids advertised in leading magainzes—each one small enough to be fitted out of sight, within the ear, and each one more powerful than its rivals.

All of them work.

Organizations already exist whose purpose is to preserve certain corpses in "deep freeze" against the day when medical advancements make it possible to bring them back to life.

Against such advanced speculation, it hardly comes as a surprise to learn that Swedish scientists are already hard at work testing an "abortion pill."

A pregnant woman, given a dose of this drug, designated F-6103, begins menstruating in a few days. She can lose with the menstrual flow a fertilized egg—or even a fetus eight weeks old or older. All this happens painlessly.

Further testing must be done on this drug. Preliminary testing on mice and monkeys was successful; and testing on a limited number of women so far shows the pill to be completely harmless.

Some doctors believe the A-pill—or, as most of its developers prefer to call it, the M- (for menstruation pill—may result in the safest answer yet for women pregnant with unwanted children.

Some even see the day when it might become the most universal method of birth control. At present use of such a pill would seem to conflict with views of the Roman Catholic Church. But, as a recent article in the *Ladies' Home Journal** indicated, someday there may

**Those New Swedish Abortion Pills,* by Ruth Link, *Ladies' Home Journal,* June, 1967.

be a shift in religious thought that would permit a woman to take such a pill without violating her faith.

The *Journal* article quoted Dr. Lars Engstrom, who is director of the Swedish experiments, as saying he thinks such a pill might some day become the standard method of birth control.

"A woman could take the pill at the end of every 28-day cycle in which she has had intercourse," says Dr. Engstrom. "Then her period will occur, whether she has a fertilized egg in her or not. In fact, she doesn't even have to think about that question at all."

Engstrom points out that the question of just when human life begins is debatable. The laws of many nations—as well as the Roman Catholic Church—presently assume that life begins when the egg and sperm unite. But, the *Journal* article adds:

"Many moralists and scientists are now suggesting that perhaps life begins when the fertilized egg attaches itself inside the uterus and begins to grow—an event called nidation, which takes place several days after conception.

"Dr. Engstrom goes even further. He believes that a life is not a life until the fetus has begun to produce its own hormones that are necessary for its survival—that is, about the seventh or eighth week after conception."

If this idea proves acceptable to church dogma and is reflected in changing laws, A-pills (or M-pills) could become the birth-control method of the future—a future which might await us just around the historical corner.

But, as exciting, spooky or downright terrifying as a glimpse into the future of medicine might hold for some of us, we should not lose sight of our present medical problems. Slight good technical improvements

of the future will do those of us who still are destined to die needless deaths at the hands of incompetent doctors.

Perhaps in this age of revolt, it's high time for a patient rebellion. The best way we might soon narrow the communication gap which has developed between doctor and patient is to let the physician know that we —his patients—are humans. Maybe one reason so many doctors approach their practice with the same impersonality as a veterinarian is that we have let them falsely assume that we have no more curiosity than animals.

Let's try to begin a new dialogue with doctors by beginning to ask them questions. Let's no longer be content to accept a quick pat on the arm and a hastily scrawled and mostly illegible prescription blank as an automatic cure for what ails us.

What can one do in such a case?

Ask him what's wrong with you. If he offers a polysyllabic phrase by way of an answer, ask him what it means.

Be persistent. If the situation calls for it, ask him to draw a diagram. He should be able to. He might even be pleased by the interest shown in your disorder or disease. It might even flatter him that he has a chance to show his superior learning.

But whether it makes him happy or not, insist that he explain to you what's wrong. Remember, you're paying for his services. Be no less demanding with him than you would with a shop clerk whom you suspect might be trying to sell you shoddy merchandise.

If some doctors regard their patients as slightly less than brilliant, perhaps the doctor isn't entirely at fault. While many shoppers study such publications as *Consumer Reports* and know how to shop for a new auto or TV repairman, they haven't the slightest idea how to find a reliable doctor in a new community. While they make all arrangements for their new home ahead of time—investigating supermarkets, schools and even laundrymats—they seldom give a second thought to the doctor they'll eventually need, until that need is hard upon them.

The least they could do would be to make sure that the strange doctor they first visit is a licensed one and in good standing with his professional society. The doctor they have visited in their old hometown should be able to furnish a few names of reputable doctors in the new city from his medical registry books—and should do so willingly. He may even happen to know personally of a reputable doctor in the new community.

In either case, such advance medical planning should be worth the small amount of time required to visit the doctor one has known—even if he charges for it. And in some instances, at least, he probably will.

The medical consumer should be aware of the dangers which sometimes threaten him and his loved ones when slipshod medical practice is engaged in by even reputable doctors and attendants at name hospitals. He should assume nothing, take nothing for granted. He should inform himself as much as possible about what's going on. He should, moreover, let the physicians and technicians involved in his case know that he's not only curious and concerned but is capable of being highly skeptical. This vigilant attitude might help keep routine-minded personnel on their toes.

Above all, one needing medical attention should steer away from do-it-yourself nostrums, specialized quacks and those who promise magical short cuts. As

fraught with danger as conventional paths of medicine sometimes are, to stray far from them is to ask for disaster.

The medical consumer shouldn't be content to be on the lookout for weaknesses and frauds in the present system. As an intelligent citizen, he should ask himself where the system is taking us. Our next generation of doctors will be only as good as today's medical schools. What's being done about enlarging existing schools and building new ones to handle the overload of students?

Tomorrow's hospitals will be only as good as the ones being planned today. Will these be equipped to handle the increased demand for beds and the latest techniques available?

Public health is, after all, the public's problem. This means it's the responsibility, to some extent, of all of us. We shouldn't expect good things merely to happen —or abuses to correct themselves.

As long as our voices are still healthy, we should make them heard. If we're in a position to talk to our lawmakers, fine. If not, we should write them—even if this means skipping an occasional letter home to dear Aunt Tilly.

But to act intelligently, lawmakers should know how we voters feel about such vital issues as higher Federal drug-testing standards.

Should medical practices be more stringently policed? Considering the importance of their profession to the general welfare, should doctors be required to remain "on call" for emergencies through some kind of community rotational system?

Or has, indeed, the growing needs of an ever more complex society outmoded the laissez-faire doctrine which most doctors continue to pursue? Like robber

barons of old, many continue to exhibit an attitude of "to hell with the public."

Has the time come to shake ourselves free of the emotional responses we sometimes experience when we hear the term socialized medicine? Let's remember that this emotional tag of socialism has been applied in the past to many institutions we now accept in our democracy—beginning, first: to the idea of a Federal government Post Office and, more recently, to Social Security.

Whatever solution we decide upon, we should resolve to tolerate no longer a lackadaisical system which jeopardizes our lives at will.

And, while making up our minds about just what to do, we should remember:

—The taxpayer will be called on to contribute ever more money for the schools in which doctors will learn their trade.

—The taxpayer will be called on to pay for a great deal of research in which doctors increase their knowledge.

—The taxpayer will have to pay for many more hospitals which doctors will use as a base of operations while growing rich.

Can't the taxpayer, then, at least expect some changes?

Should he expect to hear only an empty echo on those sad and desperate occasions when the cry arises, "Is there a doctor in the house?"

"Three faces wears the doctor: when first
sought An Angel's; and a god's the cure
half-wrought; But when, the cure complete,
he seeks his fee, The Devil
looks less terrible than he."

—Anonymous

"Now when a doctor's patients are perplexed,
A consultation comes in order next—
You know what that is? In a certain place
Meet certain doctors to discuss a case
And other matters, such as weather, crops,
Potatoes, pumpkins, lager-beer, and hops."

—Oliver Wendell Homes
(Rip Van Wrinkle, M.D.)

"Better to hunt in fiields, for
health unbrought, Than fee the doctor
for a nauseous draught. The wise,
for cure, on exercise depend; God
never made his work for man to mend."

—John Dryden *(Epistle to John Dryden of Chesterton)*

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